

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S 69032**

PLACE OF DEATH

County of **Bannock**
City of **Pocatello**

Registration District No. **28**

Primary Registration District No. **2161**

Local Registrar's No. **5746**

(If death occurred in a hospital or institution, give its name instead of street and number.)
526 E. Hayden

2. FULL NAME

(a) Residence No. **526 E. Hayden** St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

mexican

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

Jan-19-1930

7. AGE

Years Months Days

Stillborn

If LESS than 1 day,
hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

Pocatello Idaho

10. NAME OF FATHER

Jose Montano

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

mexico

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

unknown

14. Informant

Jose Montano
Pocatello, Id.

15. Filed

1/31, 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

1-19-30
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to **1-19**, 19**30**

that I last saw h_____ alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Transverse delivery
conducted by midwife

CONTRIBUTORY (Secondary)

_____, (duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) **D. C. Ray** M. D.

1-19, 19**30** (Address) **Pocatello**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Angels View **Jan 20 1930**

20. Undertaker

Address

Thompson & Keady **Idaho**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 8 1930

PLACE OF DEATH

County of Built
City of Arco

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 59
Primary Registration District No. 2129

DO NOT WRITE IN THIS SPACE

State File No. S69125

Local Registrar's No. 14

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Verna Larson

(a) Residence. No. St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of V

6. DATE OF BIRTH (month, day and year) Jan. 6 - 1930

7. AGE Years Months Days 19 30 0 If LESS than 1 day, state in hrs. or min. stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. V
(b) General nature of industry, business, or establishment in which employed (or employer) V
(c) Name of employer V

9. BIRTHPLACE (city or town) Arco, Idaho (State or country)

10. NAME OF FATHER C. S. Larson

11. BIRTHPLACE OF FATHER (city or town) Malad, Idaho (State or Country)

12. MAIDEN NAME OF MOTHER Mayme Dyrland

13. BIRTHPLACE OF MOTHER (city or town) Malad, Idaho (State or Country)

14. Informant Chas. Larson (Address) Arco, Idaho

15. Filed Jan 7, 1930 T. B. Salt Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 6, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6 1930 to Jan 6 1930 that I last saw him Stillborn and that death occurred, on the date stated above, at m. The CAUSE OF DEATH* was as follows:

Stillborn

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Did an operation precede death? ✓ Date of ✓ Was there an autopsy? ✓ What test confirmed diagnosis? ✓

(Signed) J. R. Egbert M. D. Jan 6, 1930 (Address) Arco, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Arco, Idaho Date of Burial Jan-7 1930
20. Undertaker Chas. R. Larmin Address Arco, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S 69142**

PLACE OF DEATH

County of CanyonCity of NampaRegistration District No. 7Primary Registration District No. 2006Local Registrar's No. 2(If death occurred in a hospital or institution, give its name instead of street and number.)
(No. 3 mi south)2. FULL NAME Baby Potter(a) Residence. No. 3 mi south St.(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Jan. 4th 30

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Nampa, Idaho
(State or country)10. NAME OF FATHER J. H. Potter11. BIRTHPLACE OF FATHER (city or town) Grand Island, Nebraska
(State or Country)12. MAIDEN NAME OF MOTHER Margie Patrick13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)14. Informant W. H. Potter
(Address) Nampa, Idaho15. Filed 1-6, 1930 Beetha Conroy
Registrar

16. DATE OF DEATH

January 4th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 19 to 19
that I last saw h. alive on 220, 19
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:Still Born.
Pneumonia on cord caused breathing
in uterus. Infant dead at birth.
CONTRIBUTORY Version to deliver but
(Secondary) baby was dead
(duration) yrs. mos. ds.18. Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Chinical(Signed) Forrest Beltrug, M. D.1-6, 1930 (Address) Nampa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Kohlerbaum-Nampa 1-6 1930

20. Undertaker Address

Mrs. Nina M. Talley, Nampa, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 5 - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S 69458**

PLACE OF DEATH

County of *Bingham*City of *Shelley*Registration District No. *121*Primary Registration District No. *2194*Local Registrar's No. *32*(No. _____)
(If death occurred in a hospital or institution, give the name instead of street and number.)2. FULL NAME *Ellen Landon*

(a) Residence No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Female</i>	4. COLOR OR RACE <i>W</i>	5. Single, Married, Widowed, or Divorced (write the word) <i>Single</i>
6a. If married, widowed, or divorced HUSBAND of (or) WIFE of <i>✓</i>		
6. DATE OF BIRTH (month, day and year) <i>Still born Feb 27 1930</i>		
7. AGE <i>Still born</i>	Years <i>Feb 27 1930</i>	Months <i>Feb 27 1930</i>
Days <i>Feb 27 1930</i>		
If LESS than 1 day, hrs. or min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <i>Infant</i>		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		

9. BIRTHPLACE (city or town) *Regard St*
(State or country)10. NAME OF FATHER *Charles Landon*11. BIRTHPLACE OF FATHER (city or town) *Portage Wis*
(State or country)12. MAIDEN NAME OF MOTHER *Gladys Session*13. BIRTHPLACE OF MOTHER (city or town) *Portage Wis*
(State or country)14. Informant *Charles Landon*(Address) *Idaho Falls Idaho R. 3*15. Filed *Feb 28 1930* Registrar *W. H. E. atchie*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Feb. 27 1930*
(Month) (Day) (Year)17. I HEREBY CERTIFY that I attended deceased from *Still born* to *Still born*, 19____
that I last saw him alive on _____, 19____
and that death occurred on the date stated above at _____ m.
The CAUSE OF DEATH* was as follows:
*Not known*CONTRIBUTORY (Secondary) _____
(duration) yrs. mos. ds.18. Where was disease contracted? *Not known*
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) *W. H. E. atchie* M. D.
Feb 28 1930 (Address) *Shelley Ida*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal *Coshua, Idaho* Date of Burial *Feb 28 1930*

20. Undertaker _____ Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED MAR 10 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **S 69525**

PLACE OF DEATH

County of Canyon
City of Nampa

CERTIFICATE OF DEATH

Registration District No. 7Primary Registration District No. 1006(No. Samaritan Hospital)Local Registrar's No. 35

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dale Herring(a) Residence. No. St.

(Usual place of abode.)

Length of residence in city or town where death occurred. yrs. mo. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word.) Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Feb. 21st 19307. AGE Years Months Days 6 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Nampa
(State or country) Idaho10. NAME OF FATHER A. R. Herring11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)12. MAIDEN NAME OF MOTHER Ester M. Good13. BIRTHPLACE OF MOTHER (city or town) Id.
(State or Country)14. Informant A. R. Herring
(Address) Nampa Idaho15. Filed 3-5, 1930 D. H. Conway
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 21, 1930
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb 21, 1930, to Feb. 21, 1930
that I last saw him alive on Feb. 21, 1930
and that death occurred, on the date stated above, at _____ m.*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:Self Bom

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? HomeDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? W.C. Miller

(Signed)

Feb 27, 1930 (Address) Nampa, Ida19. Place of Burial, Cremation, or Removal Kohlerlauer-Nampa Date of Burial 2-21 193020. Undertaker Mrs. Nina M. Talley Address Nampa, IdaWRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of** (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED MAR 5 - 1930
PLACE OF DEATHSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S69576**County of *Emmett*City of *Emmett*

Registration District No.

Primary Registration District No.

Local Registrar's No.

206

2. FULL NAME *Infant son Henry Duberke*
(If death occurred in a hospital or institution, give its name instead of street and number.)

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX

Male

4. COLOR OR RACE

white

5. Single, Married, Widowed, or Divorced (write the word)

Infant

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

Feb. 18 - 1930

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)

(State or country)

Emmett Idaho

10. NAME OF FATHER

Henry Duberke

11. BIRTHPLACE OF FATHER (city or town)

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Laura Meisner

13. BIRTHPLACE OF MOTHER (city or town)

(State or Country)

Idaho

14.

Informant

(Address)

*Henry Duberke
Emmett Idaho*

15.

Filed

*2/19 1930**J. K. Reynolds
Registrar*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Feb**18**30*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

at birth

19.

to

2-18-30

19.

that I last saw him alive on *2-18-30*, 19.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

*Could not get his lungs
to open up.*

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. K. Reynolds, M. D.*2/19 1930* (Address) *Emmett Idaho*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

*Emmett Idaho**2/19 1930*

20. Undertaker

Address

*C. D. Bucknum**Emmett Idaho*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S 69607**County of BoolemanRegistration District No. 30City of Coeur d'AlenePrimary Registration District No. 10.50Local Registrar's No. 35

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Gust Rutulas(a) Residence. No. 406 So 13th St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6. DATE OF BIRTH (month, day and year) Mar 4, 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0 0 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Coeur d'Alene
(State or country) Idaho10. NAME OF FATHER Gust Rutulas11. BIRTHPLACE OF FATHER (city or town) Greece
(State or Country)12. MAIDEN-NAME OF MOTHER Margie Brundage13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)14. Informant Gust Rutulas
(Address) Coeur d'Alene15. Filed 3/4, 1930 H.J. Sturgeon
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 4, 1930
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to March 4, 1930that I last saw her alive on March 4, 1930
and that death occurred, on the date stated above, at Birth 10 p.m.

The CAUSE OF DEATH* was as follows:

Premature Still born

(duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY Abnormal position of uterus
(Secondary) 3 months
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date of _____Was there an autopsy? noWhat test confirmed diagnosis? Exam(Signed) Harold J. Sturgeon, M. D.
3-6, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cemetery Date of Burial 3/6, 193020. Undertaker C.B. Mooney Address Coeur d'Alene

506

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. R.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19

MAR 19 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bonneville
City of Shoshone Falls

Registration District No. 73

Primary Registration District No. 2140

(No. _____ St.)

State File No. S 69835

Local Registrar's No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn Baby Lackyer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

F

white

(Write the word)

6. DATE OF BIRTH

February

9

1930

(Month)

(Day)

(Year)

7. AGE

Stillborn

IF LESS than 1
day how many
hrs. or
min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Baby

9. BIRTHPLACE

(State or Country)

Shoshone Falls, Idaho

10. NAME OF

Father

William Theodore Lackyer

11. BIRTHPLACE

OF FATHER

(State or Country)

Desert, Bingham County, Idaho

12. MAIDEN NAME

OF MOTHER

Genevieve Hawthorn

13. BIRTHPLACE

OF MOTHER

(State or Country)

Taylor, Bonneville, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Theodore Lackyer

(Address)

Shelly Rm #1

15.

Filed

Feb 21

1930

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2

(Month)

9

(Day)

1930

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

2-9

1930

to 29

1930

that I last saw him alive on Stillborn 1929

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

(Stillborn) about 6 months
mother suffering from effects
of Rubella

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

[Signature]

M. D.

(Address)

1000

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the

of death _____ yrs. mos. days, State _____ yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cremated

Feb 18 1930

20. UNDERTAKER

ADDRESS

Jack A. Wood

Shoshone Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **S 69854**

PLACE OF DEATH

CERTIFICATE OF DEATH

County of

City of

Registration District No. **7**Primary Registration District No. **2006**(No. **Suwan Falls 20 am**)Local Registrar's No. **37**

2. FULL NAME

Baby Barker

(a) Residence. No.

(Usual place of abode.)

Length of residence in city or town where death occurred.

yrs.

mos.

da.

How long in U. S. if of foreign birth?

yrs.

mos.

da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. Single, Married, Widowed, or Divorced (write the word) **Single**

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) **March 21**

7. AGE

Years

Months

Days

If LESS than 1 day,
hrs. or
no min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work.(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) **Suwan Falls**
(State or country) **Idaho**10. NAME OF FATHER **Irvin Barker**11. BIRTHPLACE OF FATHER (city or town) **Albion**
(State or Country) **Idaho**12. MAIDEN NAME OF MOTHER **Iretta Baugh**13. BIRTHPLACE OF MOTHER (city or town) **Utah**
(State or Country)14. Informant (Address) **W. H. Barker**
Suwan Falls, Idaho15. File No. **2-27-30** Registrar. **Beth Combs**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 26th 19**30**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3-26-30 to **3-26-30**
that **Infant was still born**
and this death occurred, on the date stated above, at **3 A. M.***State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:**Premature birth.**

(duration) yrs. mos. da.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. da.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) **W. H. Barker**, M. D.

, 19. (Address)

19. Place of Burial, Cremation, or Removal

Date of Burial

Kohlerlawn-Nampa **3-27-30**

20. Undertaker

Address

W. H. D. Talley **Nampa, Idaho**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.
N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY.
Exact statement of OCCUPATION is very important. See instructions on back.

PHYSICIAN

Exact statement of OCCUPATION is very important. See instructions on back.

NOB

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of** (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **S 69855**

PLACE OF DEATH

CERTIFICATE OF DEATH

County of

City of

Registration District No.

Primary Registration District No. **2006**

(No.)

Local Registrar's No. **276**

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME **Baby Barker**

(a) Residence. No. St.

(Usual place of abode.)

Length of residence in city or town where death occurred. yrs. mos. ds.

(If nonresident give city or town and State.)
How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 5. Single, Married, Widowed, or Divorced (write the word.) **single**5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) **March 26th 1930**7. AGE Years Months Days If LESS than 1 day, hrs. or min. **no**

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) **Sugar Falls**
(State or country) **Idaho**10. NAME OF FATHER **Llew Barker**11. BIRTHPLACE OF FATHER (city or town) **Albion**
(State or Country) **Idaho**12. MAIDEN NAME OF MOTHER **Loretta Baugh**13. BIRTHPLACE OF MOTHER (city or town) **Utah**
(State or County)14. Informant **W. M. Barker**
(Address) **Idaho**15. Filed **3/27 1930** **Barker**
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **3-26-30**
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **3-26-30** to **3-26-30**, 19**30**
that **infant** was **stillborn**,
and that death occurred, on the date stated above, at.....m.*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:**Premature birth**

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) **W. H. Frazer**, M. D.

, 19..... (Address)

19. Place of Burial, Cremation, or Removal Date of Burial

Kohlerdown-Narita **3-27 1930**

20. Undertaker Address

W. H. Frazer **Idaho**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

PHYSICIAN

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.

Exact statement of OCCUPATION is very important. See instructions on back.

Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of** (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 10 1930
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. **S 70035**

County *of Lem Falls*
City of *Lem Falls*

Registration District No.
Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME *Baby Denhart*

(a) Residence. No. St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. (Single, Married, Widowed, or Divorced (write the word)) <i>Single</i>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year) <i>Mar. 16 / 1930</i>		
7. AGE Years <i>X</i>	Months <i>X</i>	Days <i>X</i> LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (city or town) (State or country) <i>Idaho</i>
10. NAME OF FATHER <i>W. Denhart</i>
11. BIRTHPLACE OF FATHER (city or town) (State or Country) <i>Iowa</i>
12. MAIDEN NAME OF MOTHER <i>Marie Russell</i>
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) <i>Utah</i>
14. Informant <i>W. Denhart</i> (Address) <i>Buhl</i>
15. Filed <i>April 5th</i> , 1930 <i>Elizabeth J. Smith</i> Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *March 16* 19 *30*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....
that I last saw him alive on....., 19.....
and that death occurred, on the date stated above, at.....m.
The CAUSE OF DEATH* was as follows:
was born dead result of
extensive burns of mother
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?
Did an operation precede death? Date of.....
Was there an autopsy?
What test confirmed diagnosis:
(Signed) *Chas. R. Scott*, M. D.
3-21, 1930 (Address) *Lem Falls Ida.*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal *Buhl* Date of Burial *Mar 22* 19 *30*
20. Undertaker *F. H. Drake* Address *Lem Falls*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S70493**

PLACE OF DEATH
County of **Bonneville**
City of **Tona**

Registration District No.

Primary Registration District No.

Local Registrar's No. **75**

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME **Baby Cloward**

(a) Residence. No. **Tona, Idaho** St.

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

7. SEX Male	8. COLOR OR RACE White	9. Single, Married, Widowed, or Divorced (write the word) Single
10. If married, widowed, or divorced HUSBAND of (or) WIFE of		
11. DATE OF BIRTH (month, day and year) April 13, 1930		
12. AGE Years 0	Months 0	Days 0
If LESS than 1 day, hrs. or min.		
13. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Baby (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

MEDICAL CERTIFICATE OF DEATH

14. DATE OF DEATH
April 13 19**30**
(Month) (Day) (Year)

15. I HEREBY CERTIFY, That I attended deceased from **April 13**, 19**30**, to **April 13**, 19**30**
that I last saw him alive on **April 13**, 19**30**
and that death occurred, on the date stated above, at **9:30 a** m.
The CAUSE OF DEATH* is as follows:
Still Born

CONTRIBUTORY
(Secondary)

16. Where was disease contracted
if not at place of death? _____
(duration) yrs. mos. ds.

17. Did an operation precede death? _____ Date of _____
Was there an autopsy? _____
What test confirmed diagnosis? _____
(Signed) **Geo. A. Truffer, M.D.**
19 _____ (Address) **Idaho Falls, Idaho**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. BIRTHPLACE (city or town) **Tona, Idaho**
(State or country)

19. NAME OF FATHER **Lenon Cloward**

20. BIRTHPLACE OF FATHER (city or town) **Tona, Idaho**
(State or Country)

21. MAIDEN NAME OF MOTHER **Elda Knowles**

22. BIRTHPLACE OF MOTHER (city or town) **Tona, Idaho**
(State or Country)

23. Informant **Mrs. Low, M. Knowles**
(Address) **Tona, Idaho**

24. Filed **May 1, 1930** Registrar

25. Place of Burial, Cremation, or Removal **Tona, Idaho** Date of Burial **April 14 1930**

26. Undertaker **Jack A. Wood** Address **Idaho Falls**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70613 S

PLACE OF DEATH
County of Blaine
City of Rupert

Registration District No. 19
Primary Registration District No. 2015

Local Registrar's No. 18

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wanda Louise Richardson

206

(a) Residence. No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX A
4. COLOR OR RACE _____
5. Single, Married, Widowed, or Divorced (write the word) _____
5a. If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____
6. DATE OF BIRTH (month, day and year) still
7. AGE Years _____ Months _____ Days _____ If LESS than 1 day, hrs. or min. _____
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) Child
(c) Name of employer _____

9. BIRTHPLACE (city or town) Rupert Idaho
(State or country)
10. NAME OF FATHER J. L. Richardson
11. BIRTHPLACE OF FATHER (city or town) Kentucky
(State or Country)
12. MAIDEN NAME OF MOTHER Lenora Bond
13. BIRTHPLACE OF MOTHER (city or town) Nebraska
(State or Country)

14. Informant J. L. Richardson
(Address) Rupert Idaho

15. Filed 6-10, 1930 E. B. Moore
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 19 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
that I last saw h. _____ alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:
Asphyxia neonatorum
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____
Did an operation precede death? _____ Date of _____
Was there an autopsy? _____
What test confirmed diagnosis? _____
(Signed) Layne A. Keegan M. D.
5-13, 1930 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rupert Cemetery Date of Burial Apr 20 1930
Undertaker W. A. Goodman Address Rupert

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

NO B

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25-M, 1-12-1930
RECEIVED JUL 11 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 71007
Registered No. 71007

1. PLACE OF DEATH
County of Custer
City of Darlington Ida. (No. _____, St.)
Registration District No. 72
Primary Registration District No. 2153

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Fullmer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH June 15 1930
(Month) (Day) (Year)

7. AGE Still Born IF LESS than 1 day
Yrs. Mos. ds. how many hrs. or min.?

8. OCCUPATION Infant
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Darlington Ida.
(State or Country)

10. NAME OF FATHER Albert W. Fullmer

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Norma Richardson

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. F. Fullmer
(Address) Robert's Star Route

15. 7/7 1930 Rose Nowack
Filed Local Registrar

16. DATE OF DEATH Still Born
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19__ to 19__ that I last saw h alive on 19__ and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

Still Born
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Charles Baker M. D.
19__ (Address) Markay

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Darlington Ida. DATE OF BURIAL June 16 1930

20. UNDERTAKER Wm. H. Kellm. Orsbury ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S 71981**

PLACE OF DEATH
County of Oneida
City of Oneida

Registration District No. 37
Primary Registration District No. 2086

Local Registrar's No. 306

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dorothy Bonford

(a) Residence. No. Filer St.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OF RACE white 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 23/30

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Still

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

10. NAME OF FATHER R C Bonford

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Florine Jordan

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant R C Bonford (Address) Filer

15. Filed July 9th 1930 Elizabeth G. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 23 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23, 1930 to June 23, 1930
that I last saw her alive on June 23, 1930
and that death occurred, on the date above, at 2:52 a.m.
The CAUSE OF DEATH* was as follows:

Still birth

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Brach pnenatation
Instrumental (duration) One hour ds.

18. Where was disease contracted if not at place of death? Instrumental Delivery
Did an operation precede death? No
Was there an autopsy? No

What test confirmed diagnosis? Clinical
(Signed) A. D. Wright, M. D.
June 23rd 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Filer Date of Burial Jan 23 1930

20. Undertaker H. D. Drake Address Oneida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient; e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc.; Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A-25 M. 1-19

RECEIVED AUG 8 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 27

County of Franklin

Primary Registration District No. 2119

City of Franklin

(No. St.)

File No. 71221

Registered No. 58

If death occurs away from
usual residence, give facts
called for under special in-
formation.

If death occurred in a ho-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME

Infant Egan

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female white Single
(Write the word.)

6. DATE OF BIRTH

August 3 1930
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many 0 hrs.
or 0 min. 7

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

None

9. BIRTHPLACE

(State or Country)

Franklin, Idaho.

10. NAME OF
FATHER

William Ranson Egan

11. BIRTHPLACE
OF FATHER

(State or Country)

Richmond, Utah

12. MAIDEN NAME
OF MOTHER

Lulu Peterson

13. BIRTHPLACE
OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Ranson Egan

(Address)

Franklin, Idaho

15.

Filed 19

Local Registrar

16. DATE OF DEATH

August 3 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 3 1930, to Aug 3 1930
that I last saw her alive on Aug 3 1930
and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Rayna accident to
delivery, Resistant
Anesthesia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

Aug 3 1930 (Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Richmond, Utah Aug 3 1930

20. UNDERTAKER

ADDRESS

Phu M. Richards Logan, Utah

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

RECEIVED AUG 9 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **S 71291**

PLACE OF DEATH

County of AdaCity of Bowen

CERTIFICATE OF DEATH

Registration District No. 2Primary Registration District No. 1004(No. St Lukes)Local Registrar's No. 2052. FULL NAME Stanley Gordon Jr.(a) Residence. No. 1206 No. 13th St.

(Usual place of abode.)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>m-</u>	4. COLOR OR RACE <u>Wht</u>	5. Single, Married, Widowed, or Divorced (write the word.) <u>Single</u>
---------------------	--------------------------------	---

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of -

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
--------	-------	--------	------	--

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work -(b) General nature of industry, business, or establishment in which employed (or employer) -(c) Name of employer -9. BIRTHPLACE (city or town) Bowen
(State or country) Ida

PARENTS

10. NAME OF FATHER Stanley B Gordon11. BIRTHPLACE OF FATHER (city or town) Wenatchee
(State or Country) Ida12. MAIDEN NAME OF MOTHER Eveline S. Stewart13. BIRTHPLACE OF MOTHER (city or town) Ontario Ore
(State or Country)14. Informant Stanley B. Gordon
(Address) 1206 - 13th St Bowen Ida15. Filed 7-21, 1930 W.H. Rhodes
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 16, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 16, 1930, to Jan, 1930that I last saw him alive on July 16, 1930and that death occurred, on the date stated above, at 6 PM.*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:Premature birth
(6 1/2 months fetus)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) W.H. Rhodes, M. D.July 17, 1930 (Address) Bowen Ida

19. Place of Burial, Cremation, or Removal Date of Burial

Morris Hill Cemetery July 17 1930

20. Undertaker Address

Schreiner McLean Bowen Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. E.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
Physician should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid House-keepers, who receive a definite salary),** may be entered as **Housewife, Housework, or At Home,** and children not gainfully employed, as **At school or At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.,** of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back.

RECEIVED JUL 21 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **S 71397**

PLACE OF DEATH

County of **Cassia**

City of **Burley**

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No. **347-Overland, ave.**)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME **Baby Dewey (Infant)**

(a) Residence. No. **347-Overland** St.

(Usual place of abode.)

(If nonresident give city or town and State.)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. ~~Single~~ Married, Widowed, or Divorced (write the word.) **Single**

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) **June 12-1930**

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) **Burley Idaho.**
(State or country)

10. NAME OF FATHER **Edie Dewey**

11. BIRTHPLACE OF FATHER (city or town) **Idaho**
(State or Country)

12. MAIDEN NAME OF MOTHER **Elizabeth Camp.**

13. BIRTHPLACE OF MOTHER (city or town) **Idaho.**
(State or Country)

14. Informant **Mrs E. S. Dewey**
(Address) **Burley, Ida.**

15. Filed **7-11-30** 19 **30** **L. H. Cutler**
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **June 12 1930**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to, 19.....

that I last saw him alive on, 19.....

and that death occurred, on the date stated above, at **11:45 A.M.**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

**Seven months Gestation
Premature Birth
(death in utero)**

(duration) yrs. mos. ds.

CONTRIBUTORY **Song Auto Ride with**
(Secondary) **wrong**

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? **✓**

Did an operation precede death? **no** Date of

Was there an autopsy? **no**

What test confirmed diagnosis? **✓**

(Signed) **E. S. Dewey** M. D.

June 16, 1930 (Address) **Burley, Ida.**

19. Place of Burial, Cremation, or Removal **Albion Cemetery**

Date of Burial **9/12/30**

20. Undertaken **D. E. Johnson**

Address **Paris Falls**

Burley **Idaho**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Saleman, (b) Grocery;** (a) **Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid House-keepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of** (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. S71295

PLACE OF DEATH

County of BlaineCity of ShoshoneRegistration District No. 16Primary Registration District No. 1016Local Registrar's No. 15(No. 206)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Toby, Still Born(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word)5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of 6. DATE OF BIRTH (month, day and year) Aug 8 - 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer 9. BIRTHPLACE (city or town) Shoshone Ida
(State or country)10. NAME OF FATHER Lester Cannon11. BIRTHPLACE OF FATHER (city or town) Colorado
(State or Country)12. MAIDEN NAME OF MOTHER Violet Butler13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)14. Informant Lester Cannon
(Address)15. Filed Aug 9 19 30 J. L. Fuller
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 8 19 30
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Aug 8 19 30, to Aug 8 19 30, that I last saw him alive on Aug 8 19 30, and that death occurred on the date stated above, at m.The CAUSE OF DEATH* was as follows:
Still BornCONTRIBUTORY (Secondary) Still Born
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of Was there an autopsy? yesWhat test confirmed diagnosis? (Signed) [Signature] M. D.
19 30 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shoshone Ida Date of Burial Aug 9 193020. Undertaker B. E. Hickok Address Shoshone Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Salesman, (b) Grocery;** (a) **Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29 ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. S-1565

PLACE OF DEATH

County of BannockCity of PocatelloRegistration District No. 28Primary Registration District No. 2161(No. Pocatello General Hospital)Local Registrar's No. 5876

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Hill(a) Residence. No. Pocatello St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. Single, Married, Widowed, or Divorced (write the word)

Single

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) August 3, 1930.

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

Stillborn

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello, Idaho.
(State or country)

PARENTS

10. NAME OF FATHER

Howard P. Hill11. BIRTHPLACE OF FATHER (city or town)
(State or Country)Sterling, Idaho.

12. MAIDEN NAME OF MOTHER

Rhoda Homer13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)Idaho.14. Informant Howard P. Hill

(Address)

Pocatello, Idaho.15. Filed 8/5/30., 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August3, 1930.

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 3, 1930, to Aug 3, 1930that I last saw him alive on Aug 3, 1930and that death occurred, on the date stated above, at Stillborn, Pocatello, Idaho

The CAUSE OF DEATH* was as follows:

Six months gestation
Acute fulminating appendicitis
of mother

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

8/5/30.

19

(Address)

Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal
Mountain View Cemetery
Pocatello, Idaho.

Date of Burial

8/5/30. 19

20. Undertaker

Arthur W. HallPocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

2013

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. S 11504

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5888

(No. Pocatello General Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME (Infant Scott) Margerett Christine Scott

(a) Residence. No. Pocatello, Idaho. St.

(Usual place of abode)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If nonresident give city or town and State)

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX

Female

4. COLOR OR RACE

White

5. Single, Married, Widowed, or Divorced (write the word)

Single

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August 23, 1930.

7. AGE

Years

Months

Days

If LESS than 1 day,

0

0

0

Still-born

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello, Idaho.
(State or country)

10. NAME OF FATHER

R. E. Scott

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Helen Simonsen

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

Idaho.

14. Informant R. E. Scott

(Address) 906 West Center St. Poca., Ida.

15. Filed 8/23/30., 19

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 23, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 23, 1930, to Aug 23, 1930

that I last saw him alive on Aug 23, 1930

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Spontaneous birth - (6 months)
buried only 1 hr.

(duration) yrs. mos. ds.

CONTRIBUTORY Mother - toxemia pregnancy
(Secondary) some vomiting.

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O. F. Leall, M. D.
8/23/30., 19 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal
Mountain View Cemetery
Pocatello, Idaho.

Date of Burial
8/23/30. 19

20. Undertaker
Arthur W. Hall

Address
Pocatello

Registrar

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S2182**

PLACE OF DEATH
County *Cam. Falls*
City of *Cam. Falls*

Registration District No. *37*
Primary Registration District No. *1085*

Local Registrar's No. *162*

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME *Baby Simon*(a) Residence. No. *St.*

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. Single, Married, Widowed, or Divorced (write the word) *Single*

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14. Informant *Joe Simons*
(Address) *Feder*

15. Filed *Oct. 4, 1930* *Elizabeth J. Smith* Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 4 19 *30*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw *had* *alive on* 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

*Intra uterine hemorrhage.**Cesarian section performed.*

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? *Yes* Date of

Was there an autopsy?

What test confirmed diagnosis? *Clinical*

(Signed) *H. A. Dwyer* M. D.

Sept. 5, 1930 (Address) *Elmer, Ida.*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL

19. Place of Burial, Cremation, or Removal Date of Burial

Elmer *Sept 5 1930*

20. Undertaker *J. E. Drake* *Cam Falls*

364

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

NO 2

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc.; Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

203

DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. **S72615**

PLACE OF DEATH

County of Ada
City of Boise

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004
(No. St. Luke's Hospital)
Local Registrar's No. 298

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Douglas
(a) Residence. No. 8 miles west of Boise
(Usual place of abode.)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min. 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise Idaho
(State or country)

PARENTS

10. NAME OF FATHER Virgil Douglas

11. BIRTHPLACE OF FATHER (city or town) unknown
(State or Country)

12. MAIDEN NAME OF MOTHER Violet Taylor

13. BIRTHPLACE OF MOTHER (city or town) Blackfoot
(State or Country) Idaho

14. Informant Virgil Douglas
(Address) R. R. # 2, Boise Id.

15. Filed 11-24-30 1930 W. R. R. R.
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to Nov 22, 1930
that I last saw h./..... alive on....., 19.....

and that death occurred, on the date stated above, at.....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Stillborn at term
Cause unknown

.....(duration)yrs.mos.ds.

CONTRIBUTORY
(Secondary)

.....(duration)yrs.mos.ds.

18. Where was disease contracted
if not at place of death? No

Did an operation precede death? No Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) W. R. R. R., M. D.

....., 19..... (Address) Boise

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery Date of Burial Nov. 24 1930

20. Undertaker Summers & Kref Address Boise Id.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of** (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS,** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as **probably such,** if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
PHYSICIAN
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO

RECEIVED DEC 20 1930 DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 73094 S

PLACE OF DEATH

County of Bonneville

City of Ucon

CERTIFICATE OF DEATH

Registration District No. 73

Primary Registration District No. 2100

(No. _____)

Local Registrar's No. 219

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby - Skinner

(a) Residence. No. Ucon, Idaho St.

(Usual place of abode.)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

4. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 10, 1930

7. AGE Years 0 Months 0 Days 0 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Ucon, Idaho (State or country)

PARENTS

10. NAME OF FATHER Smith J. Skinner

11. BIRTHPLACE OF FATHER (city or town) Idaho (State or Country)

12. MAIDEN NAME OF MOTHER Jena Rasmussen

13. BIRTHPLACE OF MOTHER (city or town) Idaho (State or Country)

14. Informant Smith J. Skinner (Address) Idaho Falls Rte 2

15. Filed Nov 11, 1930 1930 Deft Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 10 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 4 p m.

State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. The CAUSE OF DEATH was as follows:

Stillborn

CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Dr. H. Anderson, M. D. Nov 11, 1930 (Address) Ruby Idaho

19. Place of Burial, Cremation, or Removal Basalt Idaho Date of Burial Nov 1930

20. Undertaker Jack G. Wood Address Idaho Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same ac-

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

cepted term for the same disease. Examples: Cerebro spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "croup"); Typhoid Fever (never report Typhoid pneumonia); Lobar Pneumonia; Bronchopneumonia ("pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthma," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

18654 04 FILED

ONLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 1-1931

JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Minidoka Registration District No. 19
City of Rupert Primary Registration District No. 2013
(No. _____ St.)
If death occurs away from usual residence, give facts called for under special information.

State File No. S 73452
Local Registrar's No. 26
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clara O. Housinger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Child
(Write the word)

6. DATE OF BIRTH Nov 23 1930
(Month) (Day) (Year)

7. AGE 0 Yrs. 0 Mos. 0 ds. IF LESS than 1 day how many hrs. or min. still

8. OCCUPATION
(a) Trade, profession or particular kind of work. Infant
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF Father Leslie Housinger

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Pearl O. Wagner

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leslie Housinger
(Address) Minidoka Idaho

15. Filed Jan. 6 1931 E. H. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 23 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1930 to 1930,
that I last saw him Stillborn alive on 1930,
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Stillborn

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) E. H. Elmore M. D.
1-6 1931 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury, and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted
If not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Rupert Cemetery DATE OF BURIAL Nov 23 1930

20. UNDERTAKER W. D. Goodman ADDRESS Rupert

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH FEB 5 1930

County of Ada
City of Boise Idaho.

No. 56 14,001-757 St.

St. Lukes Hospital

(If born in hospital or institution give name.)

Registration District No. 2

State File No.

Prim. Registration District No. 1004 Local Registrar's No. 18

FULL NAME OF CHILD

Stillbirth - Premature

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child

M

Twin
Triplet
or other?
(To be answered only in event of plural births)

and { Number
in order
of birth

Legitimate?

Y

Date of birth

Jan 14

(Month) (Day)

19 30
(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Argyrol

Number of child of this mother, including present birth 5

(a) Born alive and now living 4

Born alive but now dead

Stillborn one

FATHER
FULL NAME

Gilbert L. Boyinger

Residence (Usual place of abode)

Boise Rt #4

If nonresident, give place and State

Color or race

white

Age at last Birthday

50
(Years)

Birthplace

South Dakota
(City and State of Country)

Occupation

Chiropractor

MOTHER
FULL MAIDEN NAME

Florence Peters

Residence (Usual place of abode)

same

If nonresident, give place and State

Color or race

white

Age at last Birthday

38
(Years)

Birthplace

Kansas
(City and State or Country)

Occupation

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 742 A. M.
on the date above stated.

(Signature)

A. J. Coats

(Physician or midwife)

Address

521 Eastman Bldg

Filed

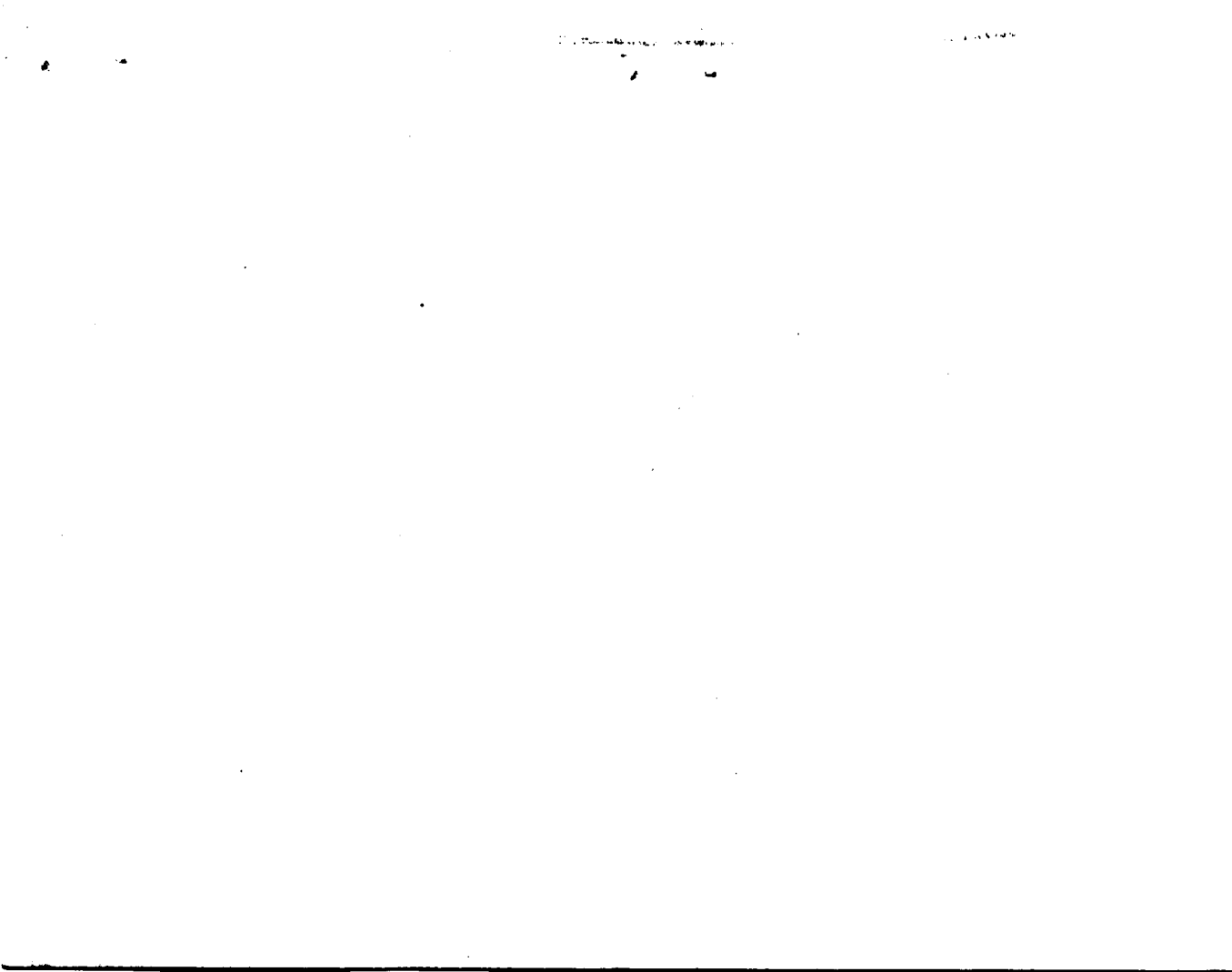
1/1/30

19

W. H. Rhodes

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 68993

PLACE OF DEATH

County of Ada.
City of Boise.

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004
(No. St. Lukes Hospital.)

Local Registrar's No. 21

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Boyenger.

(a) Residence No. St.

(Usual place of abode.)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male. 4. COLOR OR RACE White. 5. Single, Married, Widowed, or Divorced (write the word.) Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) January 14th 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or
0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Idaho.
(State or country)

10. NAME OF FATHER

G. L. Boyenger.

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Holland, Mich.

12. MAIDEN NAME OF MOTHER Florence Peters.

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Ill.

14. Informant G. L. Boyenger.

(Address) Boise, Idaho.

15. Filed 1-14-30 30 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 14th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19... to 19...
that I last saw him alive on 19...

and that death occurred, on the date stated above, at... m.

State the DISEASE CAUSING DEATH or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDE. The CAUSE OF DEATH was as follows:

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) a. Root, M. D.
1/14/30, 19... (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Date of Burial

Morris Will Cemetery. 1/14/30 19

Wm. McBratney. Boise, Ida.

MARGIN RESERVED FOR BINDING 178517

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back.

PHYSICIAN

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Saleman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile Factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home**, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At Home**, and children not gainfully employed, as **At school or At Home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia); **Lobar Pneumonia**; **Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of** (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

464 144 255
PLACE OF BIRTH FEB. 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH **S** **B** 177864

County of Boise
City of Boise
No. St. Lukes St.
(If born in hospital or institution give name.)
Registration District No. 2 State File No. 1004
Prim. Registration District No. 1004 Last Registrar's No. 51
FULL NAME OF CHILD Stillborn Moulton
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>M</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mates <u>yes</u>	Date of birth <u>Jan 17</u> 19 <u>30</u> (Month) (Day) (Year)
-----------------------	---	-----	--------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 2 (a) Born alive and now living * 1
Born alive but now dead _____ Stillborn 1

FULL NAME <u>R. S. Moulton</u> FATHER Residence (Usual place of abode) <u>2811 Pleasanton</u> If non-resident, give place and State _____ Color or race <u>White</u> Age at last Birthday <u>27</u> (Years) Birthplace <u>Boise Idaho</u> (City and State or County) Occupation <u>Farmer</u>	FULL MAIDEN NAME <u>Violet Severy</u> MOTHER Residence (Usual place of abode) <u>2811 Pleasanton</u> If non-resident, give place and State _____ Color or race <u>White</u> Age at last Birthday <u>24</u> (Years) Birthplace <u>Boise Idaho</u> (City and State or County) Occupation _____
--	---

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 11 30 P. M.
on the date above stated.

(Signature) W. H. Rhodes
(Physician or midwife)
Address Boise Idaho
Filed 1-30-30 W. H. Rhodes Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Registration
from Registrar

STATE OF NEW YORK

Number
in order
of birth

was used to receive

of child of the mother

born with her

third

born with her

born with her

born with her

born with her

born with her

born with her

born with her

born with her

born with her

born with her

born with her

born with her

born with her

born with her

born with her

born with her

born with her

MARGIN RESERVED FOR BINDING

177864

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 5 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68992

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 22
B

2. FULL NAME Infant Moulton
(a) Residence. No. 2811 Chasonton Ave., St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

206

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____
6. DATE OF BIRTH (month, day and year) January 14 1930
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (city or town) (State or country) Boise Idaho
10. NAME OF FATHER Robert S. Moulton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) California
12. MAIDEN NAME OF MOTHER Violet Loney
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Boise Id

14. Informant Mrs J. B. Loney
(Address) 2811 Chasonton Ave. Boise
15. Filed 1-15-30 U. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 14 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 14, 1930, to Jan, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

Still born.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) _____
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? _____
Did an operation precede death? no Date of _____
Was there an autopsy? no
What test confirmed diagnosis? _____
(Signed) A. W. Borch, M. D.
Jan, 19____ (Address) Boise Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial Jan 16 1930
Morris Hill Cemetery
20. Undertaker Address Boise Idaho
Summers & Truf.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO	
COUNTY OF <u>Blaine</u>		DEPARTMENT OF PUBLIC WELFARE	
CITY OF <u>Carey</u>		BUREAU OF VITAL STATISTICS	
No. <u>993 217 007 231</u>		CERTIFICATE OF BIRTH	
St. <u>231</u>		Registration District No. <u>57</u> State File No. <u>177961</u>	
(If born in hospital or institution give name.)		Prim. Registration District No. <u>2025</u> Local Registrar's No. <u>4</u>	
FULL NAME OF CHILD <u>Stillborn Richards</u>			
(If stillborn, substitute the word "Stillbirth" for name of child)			
Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>
(To be answered only in event of plural births)		Date of birth <u>1</u> <u>17</u> <u>1930</u>	(Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? <u>—</u>			
Number of child of this mother, including present birth <u>5</u> (a) Born alive and now living <u>2</u>			
Born alive but now dead <u>—</u> Stillborn <u>3</u>			
FATHER		MOTHER	
FULL NAME <u>William Benton Richards</u>		FULL MAIDEN NAME <u>Verminia Irene Stanford</u>	
Residence (Usual place of abode) <u>Carey, Idaho</u>		Residence (Usual place of abode) <u>Carey, Idaho</u>	
If nonresident, give place and State <u>—</u>		If nonresident, give place and State <u>—</u>	
Color or race <u>White</u> Age at last Birthday <u>37</u>		Color or race <u>White</u> Age at last Birthday <u>35</u>	
(Years)		(Years)	
Birthplace <u>Ogden Utah</u>		Birthplace <u>Boise Idaho City, Idaho</u>	
(City and State or Country)		(City and State or Country)	
Occupation <u>Farmer</u>		Occupation <u>Home wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 8:30 P. M. on the date above stated.

(Signature) [Signature]

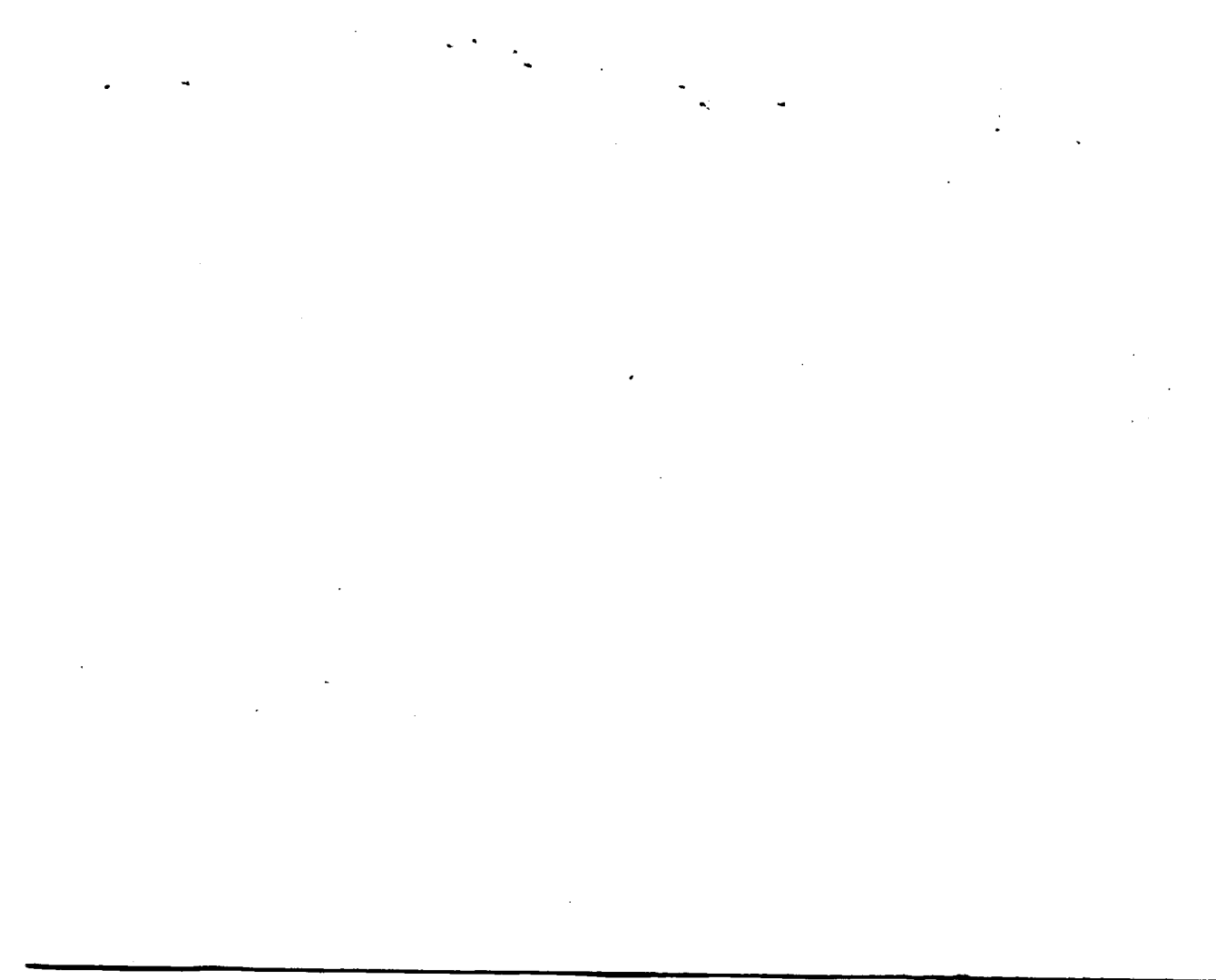
(Physician or midwife)

Address Stanley, Idaho

Filed 2-1 19 30

Registrar Robert H. Wright

2 mos. fetus - mummified
Placenta previa - external
*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1930
PLACE OF DEATH
County of Blaine
City of Larey

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69078

Registration District No. 57
Primary Registration District No. 2025

Local Registrar's No. 2

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME J. Richards

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u> </u>		
6. DATE OF BIRTH (month, day and year)		
7. AGE <u>22</u> Years <u>11</u> Months <u>11</u> Days	If LESS than 1 day, <u>0</u> hrs. or <u>0</u> min.	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u> </u> (b) General nature of industry, business, or establishment in which employed (or employer) <u> </u> (c) Name of employer <u> </u>		

9. BIRTHPLACE (city or town) Larey, Idaho
(State or country)

PARENTS

10. NAME OF FATHER <u>William Benton Richards</u>
11. BIRTHPLACE OF FATHER (city or town) (State or Country) <u>Idaho, Utah</u>
12. MARRIED NAME OF MOTHER <u>Ida Louise Mangford</u>
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) <u>Idaho, Utah</u>

14. Informant Wm B. Richards
(Address) Larey, Idaho

15. Filed 2-1, 1930 A. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
1 (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 1930, to , 1930,
that I last saw him alive on , 1930,
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Still born - 7 mos fetus - Mongolian -

(duration) yrs. mos. ds.
CONTRIBUTORY Central Placenta previa
(Secondary) (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of

Was there an autopsy?
What test confirmed diagnosis? clinical
(Signed) 1/18, 1930 (Address) Idaho, M. D.

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial <u>19</u>
20. Undertaker	Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED MAR 7 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho

MAR 3 1930

177961

Mrs. W.B. Richards
Carey

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD no name - stillborn

PLACE OF BIRTH** Carey DATE OF BIRTH Jan. 17, 1930 SEX OF CHILD Female

1. Number of children born to this mother, including present birth 5
2. Number born alive and now living 2
3. Born alive but now dead _____
4. Number of children stillborn 3

(Please write plainly)

Information with reference to
FATHER

William Denton Richards
(Full name)

Carey, Idaho.
(Residence)

Age at last birthday 37

Ogden, Utah.
(Birthplace)

Farmer & Sheepman
(Occupation)

Information with reference to
MOTHER

Vermile Louise Stanford
(Full maiden name)

Carey, Idaho.
(Residence)

Age at last birthday 34

Salt Lake City, Utah.
(Birthplace)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C. K. Macey
C.K. Macey

Special Agent, Bureau of the Census.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bonnerille
City of Idaho Falls
No. 815-1500-15 St.

L.D.S. Hospital
(If born in hospital or institution
give name.)

Registration District No. 73

State File No. 111995

Prim. Registration District No. 212 Local Registrar's No. W

FULL NAME OF CHILD

Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child

male

Twin
Triplet
or other?

and { Number
in order
of birth

Legiti-
mate? yes

Date of
birth

Jan. 15
(Month) (Day)

1930
(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2

(a) Born alive and now living 1

Born alive but now dead

Stillborn 1

(4th mo. question)

FATHER
FULL NAME Freeman Hansen

Residence (Usual place of abode) Idaho Falls

If nonresident, give place and State

Color or race white Age at last Birthday 24

(Years)

Birthplace Tropic Utah
(City and State or Country)

Occupation plumber

MOTHER
FULL MAIDEN NAME Mabel Jensen

Residence (Usual place of abode) Idaho Falls

If nonresident, give place and State

Color or race white Age at last Birthday 23

Birthplace Grover Wyoming
(City and State or Country)

Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at Idaho Falls on the date above stated.

(Signature) John O. Mello

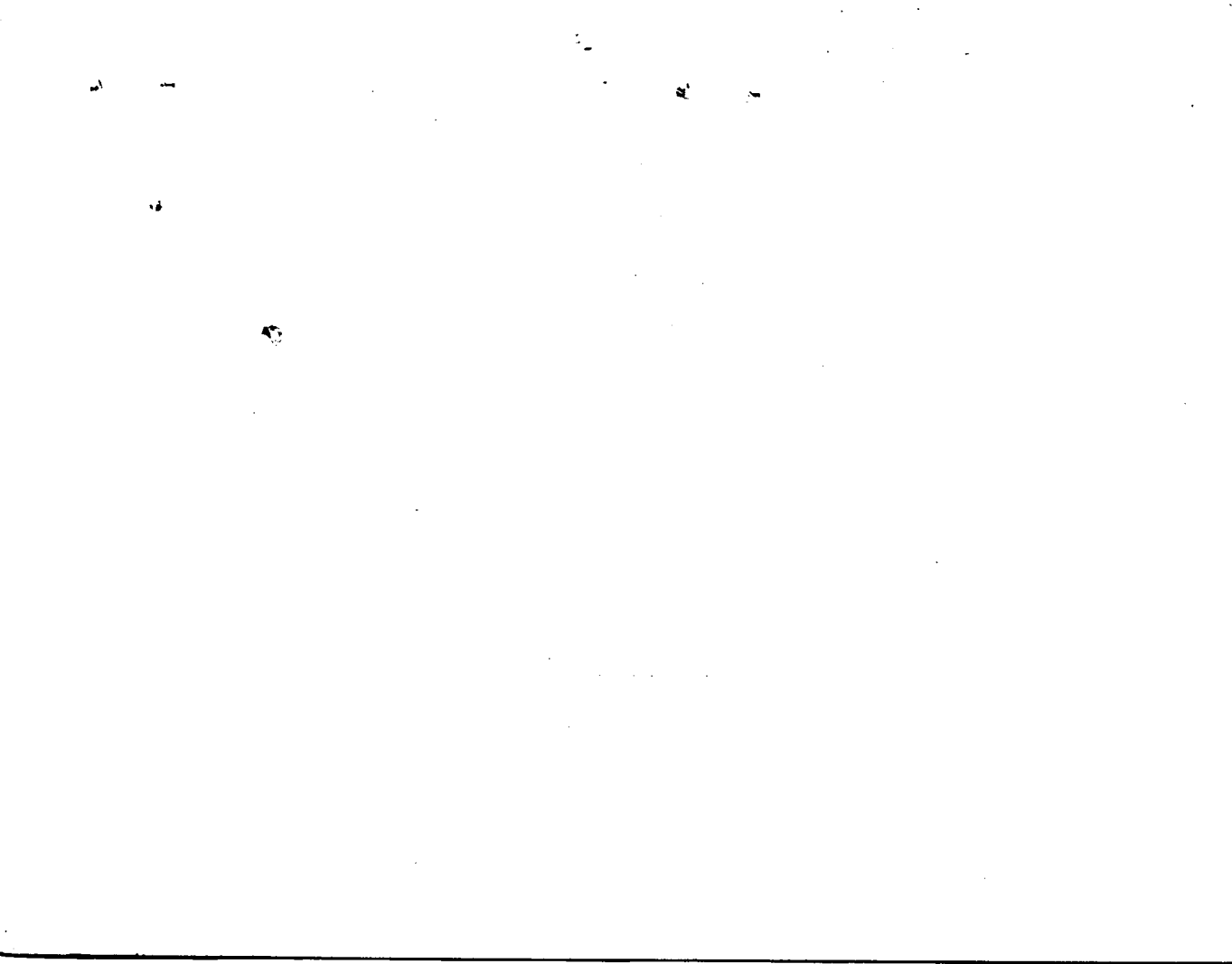
(Physician or midwife)

Address Idaho Falls, Ida.

Filed 1/21 1930

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 89110

PLACE OF DEATH

County of Bonnerille
City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2100

Local Registrar's No. 13

(No. L.D. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) new Born

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6. DATE OF BIRTH (month, day and year) 1-15-30

7. AGE Years _____ Months _____ Days _____ If LESS than 1 day, still-born hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) L.D. Hospital
(State or country) Idaho Falls Idaho

10. NAME OF FATHER

Mr. Freeman Hansen

11. BIRTHPLACE OF FATHER (city or town) Tropic
(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Mabel Jensen

13. BIRTHPLACE OF MOTHER (city or town) Greene
(State or Country) Wyoming

14. Informant Freeman Hansen
(Address) Idaho Falls Idaho

15. Filed Jan 18, 1930 Chapman
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw h. _____ alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH was as follows:
Still-born at about
4th mo. gestation
caused by overwork,
and chronic illness
(chronic endocarditis)
CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. mos. ds.

18. Where was disease contracted
if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____
(Signed) John O. Mellar, M. D.

19. (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Cremation Date of Burial 1/18-1930

20. Undertaker none Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

753130-010887
PLACE OF BIRTH RECEIVED
County of Bonanza FEB 17 1930
City of Idaho Falls
No. L.S. Hospital St.
(If born in hospital or institution give name)
Registration District No. 73 State File No. S178012
Prim. Registration District No. 2140 Local Registrar's No. 37
FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)
Sex of Child Male Twin Triplet or other? { and } Number in order of birth Legitimate? yes Date of birth Jan. 30 1930
(To be answered only in event of plural births) (Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum?
Number of child of this mother, including present birth 2 (a) Born alive and now living 0
Born alive but now dead 0 Stillborn 2
FULL NAME Dewey Peterson FATHER FULL MAIDEN NAME Violet Ball MOTHER
Residence (Usual place of abode) Idaho Falls Residence (Usual place of abode) Idaho Falls
If non-resident, give place and State If non-resident, give place and State
Color or race white Age at last Birthday 31 Color or race white Age at last Birthday 21
Birthplace Canada (Years) Birthplace Idaho Falls (Years)
(City and State or County) (City and State or County)
Occupation Auto shop worker Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 1:13 P. M.
on the date above stated.

(Signature) W. B. Sweeney
Physician
(Physician or midwife)

Address Idaho Falls, Idaho

Filed Feb 17 1930 W. B. Sweeney

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

REFUGEE CONSTITUTION

Registration District No. 116

From Registration District No. _____ Local Registrar's No. _____

photo to appear as "MIRIAM" above said captioned article.

[illegible]

What prophylactic was used to prevent spinal fluid contamination?

Number of child of this mother including present birth: (a) Born alive and now living: _____

SENATOR

SECRET

(GROUP NO. 1248 FOR 1950)

INSTITUTE OF TRAINING PHYSICIAN OF MIDWIFE.

SECRET

I hereby certify that I attended the birth of this child, who was born

on the left above stated.

(subject to analysis)

4293 b b A

॥५॥

[illegible]

CHRYSTIE'S ESTATE AGENTS, 15, N. B. STREET, LONDON, E.C. 4.
 THE PROPERTY OF THE ESTATE AGENTS, 15, N. B. STREET, LONDON, E.C. 4.
 THE PROPERTY OF THE ESTATE AGENTS, 15, N. B. STREET, LONDON, E.C. 4.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69100

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2, 4-7

Local Registrar's No. 23

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Peterson (Still born)

(a) Residence. No. 2, N. S. Hospital St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX <u>m</u>	4. COLOR OR RACE <u>white</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>—</u>
5a. If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____		
6. DATE OF BIRTH (month, day and year) <u>Jan-30-30</u>		
7. AGE <u>Three days</u>	Years <u>0</u>	Months <u>0</u>
Days <u>0</u>		If LESS than 1 day, hrs. or min. <u>0</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>—</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u> (c) Name of employer <u>—</u>		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan-30 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
that I last saw him alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:
Premature 6 1/2 mos. Still born
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death? _____
Did an operation precede death? _____ Date of _____
Was there an autopsy? _____
What test confirmed diagnosis? _____
(Signed) P. A. Ingerson M. D.
Jan-30, 1930 (Address) Idaho Falls, Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

PARENTS

9. BIRTHPLACE (city or town) Idaho Falls
(State or country) Idaho

10. NAME OF FATHER
Hervey Peterson

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Canada

12. MAIDEN NAME OF MOTHER
Viola Hall

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Idaho Falls
Idaho

14. Informant Alice L. Angles
(Address) Highway, Idaho Falls, Idaho

15. Filed 1/30, 1930 C. E. Peterson Registrar

19. Place of Burial, Cremation, or Removal
Ridge Idaho

Date of Burial 1/31 1930

20. Undertaker
—

Address
—

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED FEB 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 178055

County of Canyon
City of Baldwell
No. 3rd & Lavelle St.

Registration District No. 3 State File No. 1005

167 219 114 193

(If born in hospital or institution
give name.)

Prim. Registration District No. 1005 Local Registrar's No. 5

FULL NAME OF CHILD Baby Stillbirth for don

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u>	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Jan 19</u>	<u>1930</u>
	(To be answered only in event of plural births)			(Month)	(Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 12 (a) Born alive and now living 10

Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME Orval Jackson Jordan

Residence (Usual place of abode) Baldwell, Ida

If nonresident, give place and State

Color or race white Age at last Birthday 49

(Years)

Birthplace Kansas

(City and State or Country)

Occupation Painter

MOTHER
FULL MAIDEN NAME Ethel Wilson

Residence (Usual place of abode) Baldwell, Ida

If nonresident, give place and State

Color or race white Age at last Birthday 38

(Years)

Birthplace Jules Co Kansas

(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive
on the date above stated. Stillborn at 8:30 A. M.

(Signature) C. R. Whiteaborn

Osteopath

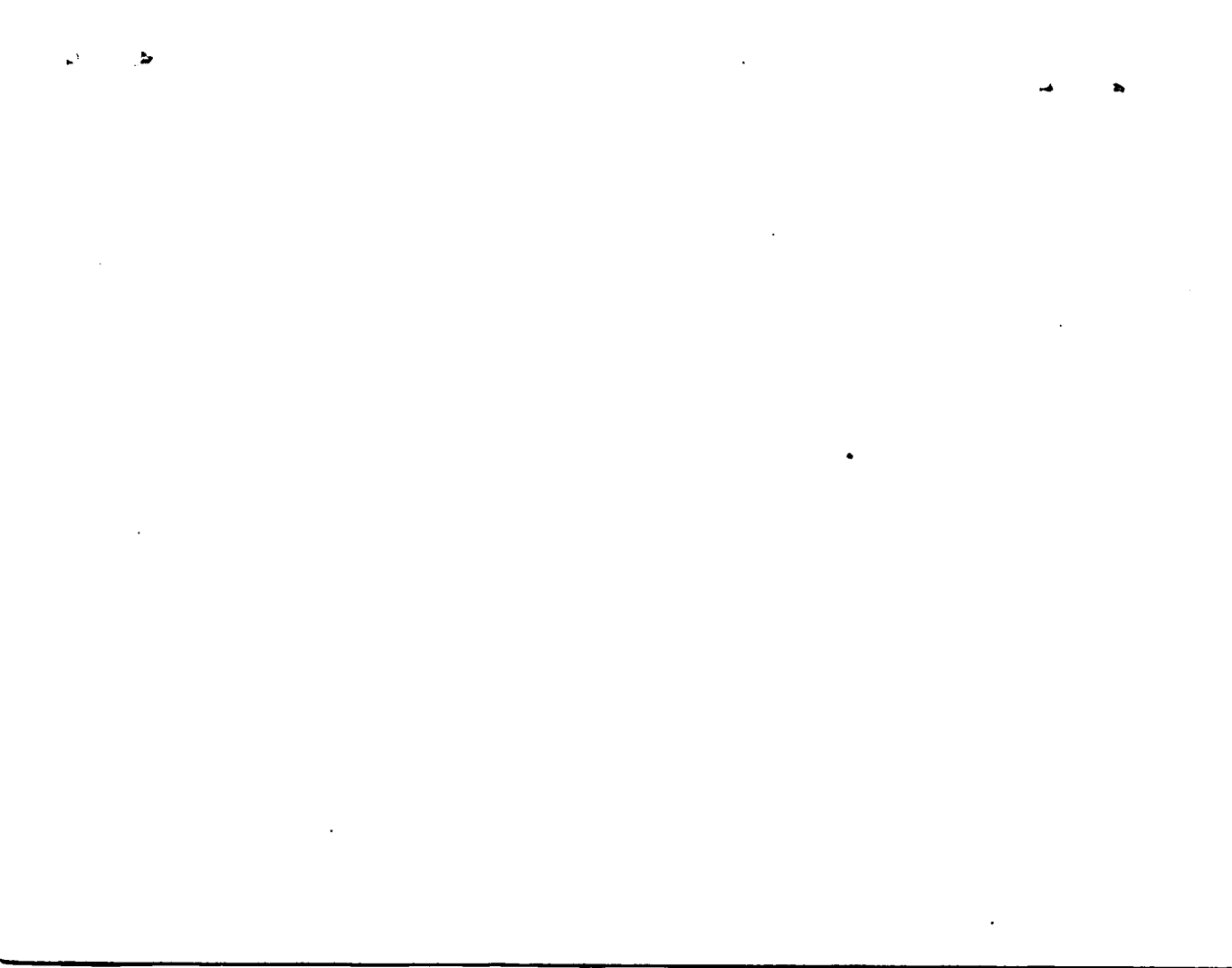
(Physician or midwife)

Address Caldwell, Idaho

Filed 1-28-1930 John H. Meyer

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



20. Undertaker	Address
Paul L. Case	Caldwell Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFAADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

County of

FEB 11 1930

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

City of

No.

St.

CERTIFICATE OF BIRTH

S 178066

Registration District No.

State File No.

(If born in hospital or institution
give name.)

Prim. Registration District No.

Local Registrar's No.

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child

Female

Twin
Triplet
or other
(To be answered
only in event of plural births)

and

Number
in order
of birth

Legiti-
mate?

Date of
birth

Jan 27 1920
(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth

(a) Born alive and now living

Born alive but now dead

Stillborn

FULL
NAME

FATHER

FULL
MAIDEN
NAME

MOTHER

Residence (Usual place of abode)

Residence (Usual place of abode)

If nonresident, give place and State

If nonresident, give place and State

Color or race

Age at last Birthday

Color or race

Age at last Birthday

Birthplace

(City and State or Country)

Birthplace

(City and State or Country)

Occupation

Occupation

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 2 P. M.
on the date above stated.

(Signature)

(Physician or midwife)

Address

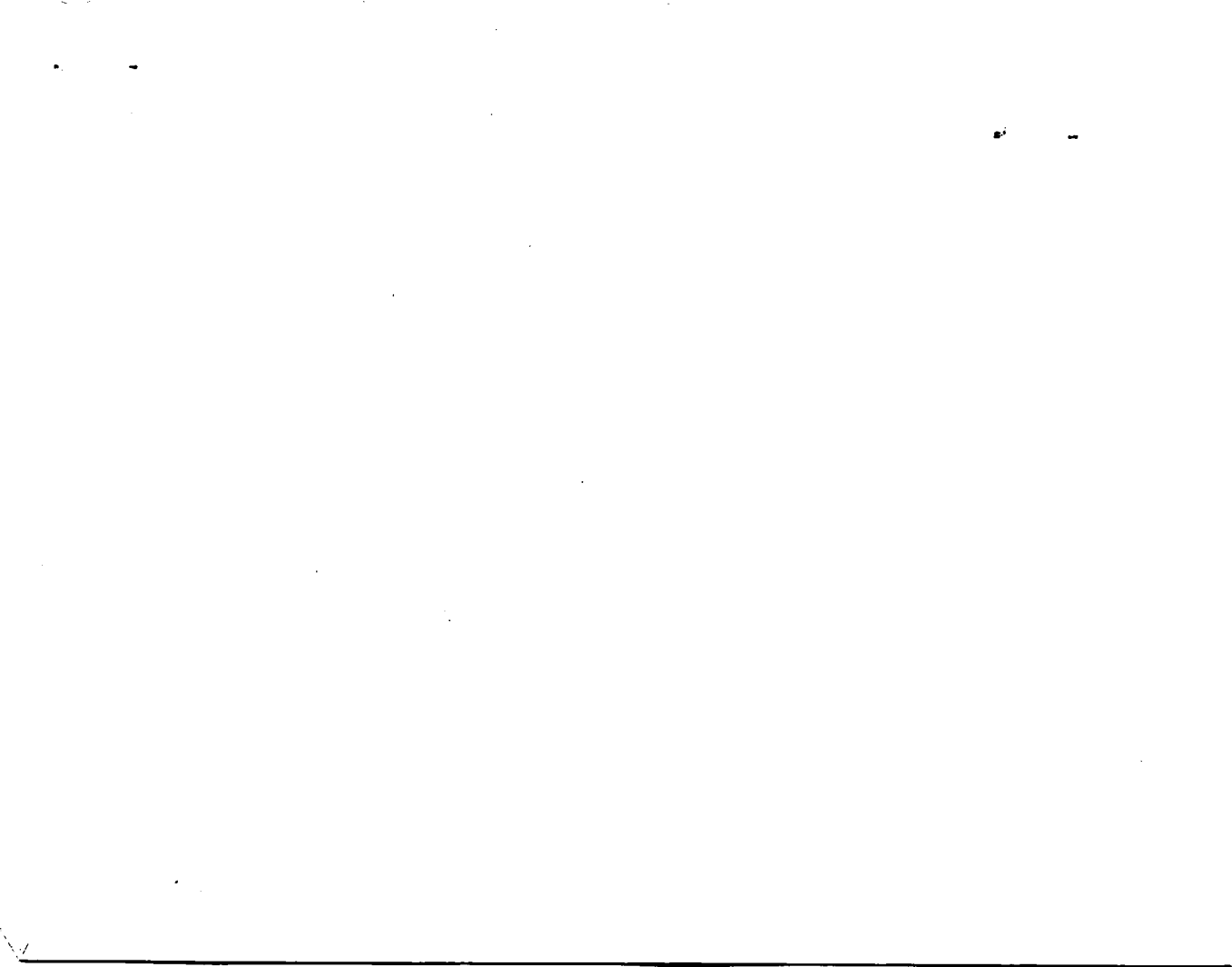
Filed

2-10-1930

John S. Meyer

Registrar

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



RECEIVED FEB 11 1930

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH.
County of Canyon
City of CaldwellRegistration District No. 3
Primary Registration District No. 2005
(No. _____, _____ St.)File No. 69130
Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(Self Born) Marie

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE
5. SINGLE, MARRIED, WIDOWED OR DIVORCED.Female White Single
(Write the word.)

6. DATE OF BIRTH

Jan 22 1930
(Month) (Day) (Year)

7. AGE

Self Born
yrs. mos. ds.
IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho Canyon Rt. 1 Notus

10. NAME OF FATHER

Clarence Marrs -

11. BIRTHPLACE OF FATHER

(State or Country) Hildgrade Ory

12. MAIDEN NAME OF MOTHER

Ethel Irene Bethel -

13. BIRTHPLACE OF MOTHER

(State or Country) Caldwell Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ms Clarence Marrs
(Address) Notus - R.F.D. No. 1

15.

Filed 2-10- 1930 John S. Mayes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 22 1930, to Jan 22 1930
that I last saw him Self Born 1930and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Crin - 30 days Premature
Instrument Delivery

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Jan 22 1930 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

at Home1-23 1930

20. UNDERTAKER

ADDRESS

Watts & Friends Caldwell
Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital)," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH.

County of Franklin RECEIVED FEB 10 1930
City of Clifton Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S178154

No. 317104021-265 St.

Registration District No. 27 State File No. _____

(If born in hospital or institution
give name.)

Prim. Registration District No. 211 Local Registrar's No. _____

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth	Legiti- mate?	Date of birth <u>Jan 4</u> 19 <u>30</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead _____ Stillborn 1

FATHER FULL NAME <u>George Merrill Capiner</u>	MOTHER FULL MAIDEN NAME <u>Melda Kofke</u>
---	---

Residence (Usual place of abode) <u>Clifton Ida</u>	Residence (Usual place of abode) <u>Clifton Ida</u>
---	---

It non-resident, give place and State _____ If non-resident, give place and State _____

Color or race <u>White</u> Age at last Birthday <u>23</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>20</u> (Years)
---	---

Birthplace <u>Farmington</u> (City and State or County)	Birthplace <u>Clifton Ida</u> (City and State or County)
---	--

Occupation <u>Station Agent C. S. L.</u>	Occupation <u>Housewife</u>
--	-----------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at _____ on the date above stated.

(Signature) Eugene Morley

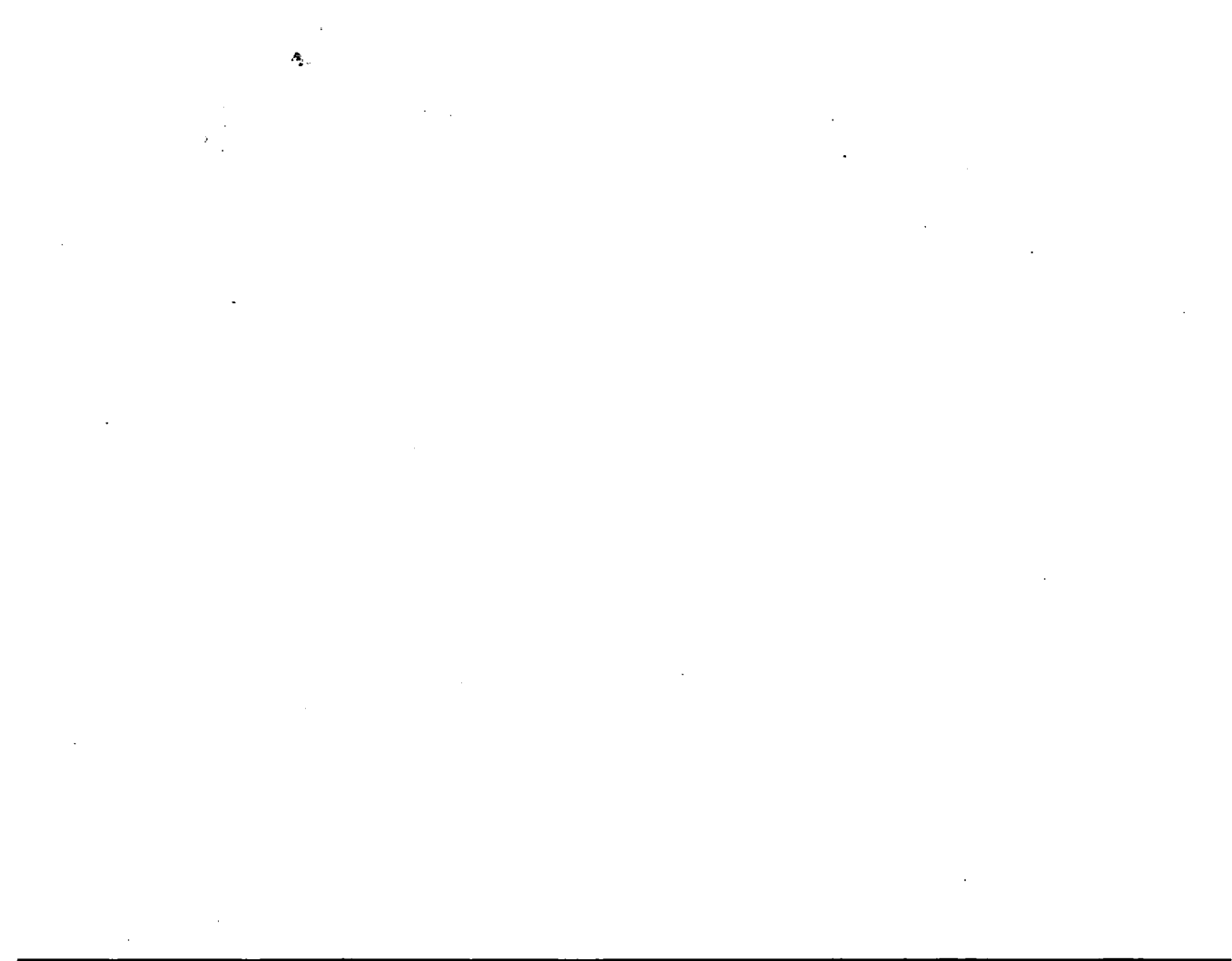
(Physician or midwife)

Address Clifton Ida

Filed Jan 7 1930 A. R. Cuth

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH—**REC- FEB 10 1930**

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S
178164

County of Franklin
City of Preston, Ida
No. 335 127 021 255 St.

Registration District No. 27 State File No. 27

(If born in hospital or institution
give name.)

Prim. Registration District No. 2119 Local Registrar's No. 2119

FULL NAME OF CHILD Still Born
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legiti- mate? <u>yes</u>	Date of birth <u>Jan 27</u> <u>1930</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? I5

Number of child of this mother, including present birth. 15 (a) Born alive and now living 13

Born alive but now dead I Stillborn I

FATHER FULL NAME <u>Harris A Stephenson</u>	MOTHER FULL MAIDEN NAME <u>Saphrona Bennett</u>
--	--

Residence (Usual place of abode) Preston, Ida

If non-resident, give place and State Utah

Color or race White Age at last Birthday 53 (Years)

Birthplace Utah (City and State or County)

Occupation Farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at I-50 A M.
on the date above stated.

(Signature) G. W. Slater

M.D.

(Physician or midwife)

Address Preston, Ida
RA, Carter

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. REG. 1-23 FEB 10 1930 CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Franklin
City of Preston, Ida

If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
State File No. 69191
Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Still born

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word)

6. DATE OF BIRTH

Jan 27 1930
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
Yrs. — Mos. — ds. — hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Child
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Preston, Ida

10. NAME OF FATHER

Harris A. Stephenson

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Sophrona Bennett

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harris A. Stephenson
(Address) Preston, Ida

15.

Filed Jan 30 1930 A. P. Butler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1930 to Jan 27 1930, that I last saw him alive Born dead TV, and that death occurred on the date stated above, at 1:50 P. M.

The CAUSE OF DEATH* was as follows: Prolapse of
umbilical cord.
Born dead - at 1:50 a.m.
of Jan 27 - 1930
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

G. W. Stokes M. D.

18. 1930 (Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Preston, Ida

DATE OF BURIAL

Jan 30 1930

20. UNDERTAKER

M. W. Hendricks

ADDRESS

Preston

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "**Laborer, "Foreman, "Manager, "Dealer, etc.,** without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers, who receive a definite salary,** may be entered as **Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "**Epidemic cerebrospinal meningitis**"); **Diphtheria** (avoid use of "**Croup**"); **Typhoid fever** (never report "**Typhoid Pneumonia**"); **Lobar pneumonia; Bronchopneumonia** ("**Pneumonia**," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "**Cancer**" is less definite; avoid use of "**Tumor**" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "**Asthenia, "Anaemia**" (merely symptomatic), "**Atrophy, "Collapse, "Coma, "Convulsions, "Debility, "Congenital, "Senile, etc.), "Dropsy, "Exhaustion, "Heart Failure, "Hemorrhage, "Inanition, "Marasmus, "Old age, "Shock, "Uraemia, "Weakness, etc.,** when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, "PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "**Contributory.**"

PLACE OF BIRTH
RECEIVED FEB 15 1930STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 178260

County of BoiseCity of GibbsNo. 554-210028-713 St.Registration District No. 30 State File No. 178260(If born in hospital or institution
give name.)Prim. Registration District No. 1050 Local Registrar's No. 14FULL NAME OF CHILD Leona Beth Vedder

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate <u>yes</u>	Date of birth <u>1 - 10 1930</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 7 (a) Born alive and now living 0Born alive but now dead 0 Stillborn 1FATHER
FULL NAME Leonard VedderResidence (Usual place of abode) Gibbs, Ida

If nonresident, give place and State

Color or race white Age at last Birthday 28
(Years)Birthplace Berlin, Wis.
(City, and State or Country)Occupation carpenterMOTHER
FULL MAIDEN NAME Beth VedderResidence (Usual place of abode) Gibbs, Ida

If nonresident, give place and State

Color or race white Age at last Birthday 20
(Years)Birthplace Ind. Wash
(City and State or Country)Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 11:30 P. M.
on the date above stated. { Stillborn }(Signature) Harold J. Sturges M.D.

(Physician or midwife)

Address Coeur d'Alene, IdaFiled 2-7 1930 H. J. Sturges
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

69260

REPORT OF THE
COMMISSIONER OF THE
BUREAU OF LAND MANAGEMENT
U. S. DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69260

PLACE OF DEATH
County of Boole
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050

Local Registrar's No. 21

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leonora Beth Vedder.(a) Residence. No. _____ St. Pitts. Ida.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1930-1-10.

7. AGE Years Months Days If LESS than 1 day,
0 0 0 hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Coeur d'Alene
(State or country) Ida.10. NAME OF FATHER Leonard Vedder11. BIRTHPLACE OF FATHER (city or town) Burlington, Wis.
(State or Country)12. MAIDEN NAME OF MOTHER Beth Potter13. BIRTHPLACE OF MOTHER (city or town) Wash.
(State or Country)14. Informant Leonard Vedder
(Address) Pitts, Ida.15. Filed 2/11, 1930. H. J. Sturges
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw him alive on _____, 19____
and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum
due to prolonged difficult
labor (duration) _____ yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. mos. ds.

18. Where was disease contracted
if not at place of death? _____Did an operation precede death? No Date of _____Was there an autopsy? NoWhat test confirmed diagnosis? Exam(Signed) Harold J. Sturges M. D.Jan 12, 1930 (Address) Ida Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Burial Date of Burial 1-12 193020. Undertaker Coeur d'Alene Address Ida Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Latah
City of RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S178287

No. 293-212-029-285 St.

Registration District No. 65 State File No.

(If born in hospital or institution give name.)

Prim. Registration District No. 245 Local Registrar's No.

FULL NAME OF CHILD

Stillbirth Infant Hill

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child

Female

Twin
Triplet
or other?

and {

Number
of birth

Legiti-
mate

Yes

Date of
birth

Jan 12

(Month) (Day)

1930
(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2

(a) Born alive and now living 1

Born alive but now dead

Stillborn

FULL
NAME

Osville J. Hill

FATHER

Residence (Usual place of abode)

Latah Co. Ida

If nonresident, give place and State

Color or race

White

Age at last Birthday

46

(Years)

Birthplace

Wash

(City and State or Country)

Occupation

Farmer

FULL
MAIDEN
NAME

Uma Sheppard

MOTHER

Residence (Usual place of abode)

Latah Co. Ida

If nonresident, give place and State

Color or race

White

Age at last Birthday

33

(Years)

Birthplace

Mo

(City and State or Country)

Occupation

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was

Stillborn

at

20

M.

on the date above stated.

(Signature)

E. K. Wolfe M.D.

(Physician or midwife)

Address

Palouse Wash

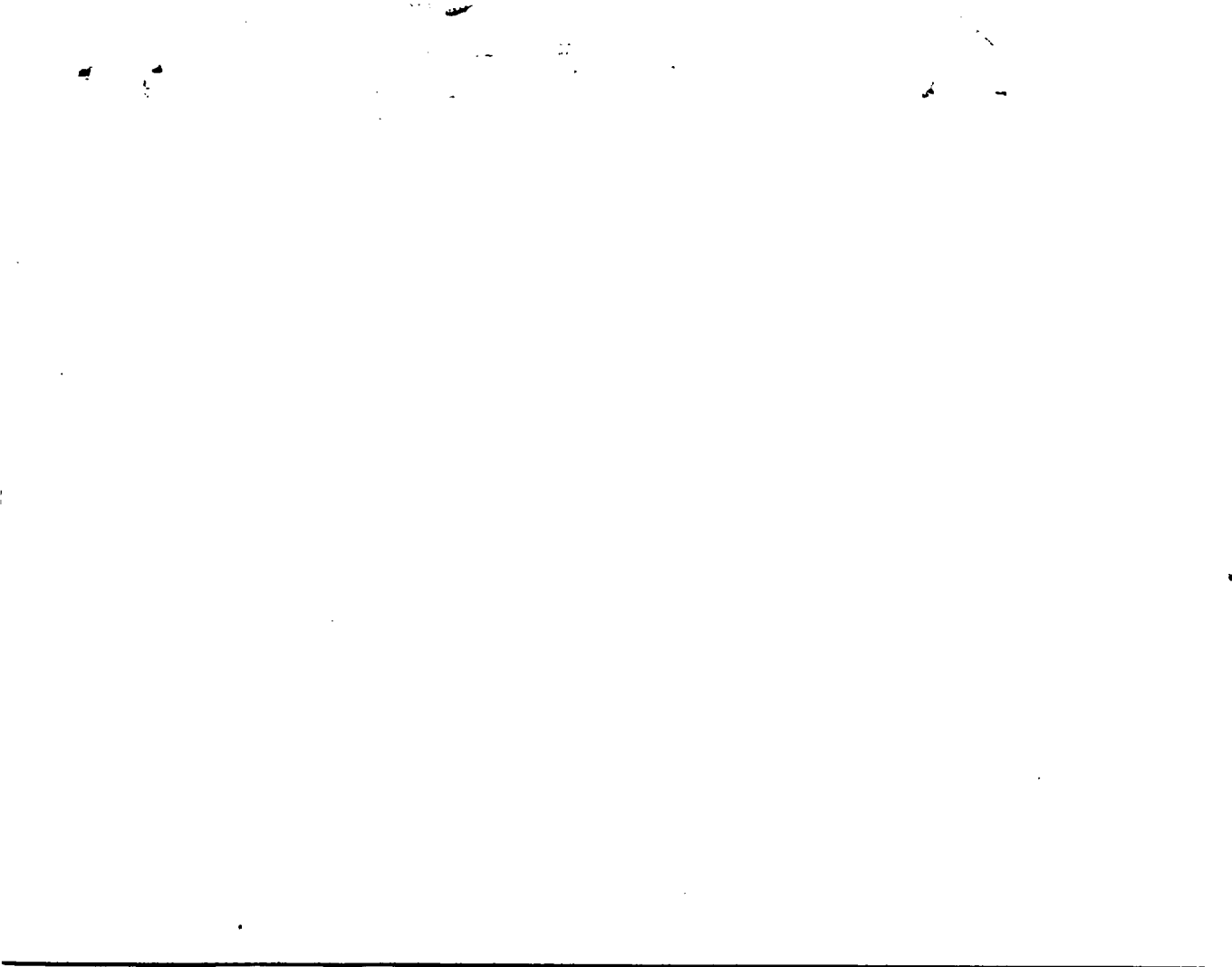
Filed

Jan 18 1930

Wm. Thompson

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69268

PLACE OF DEATH
County of *Salado*
City of *Paola*

Registration District No. *65*
Primary Registration District No. *2145*

Local Registrar's No. *704*

(If death occurred in a hospital or institution give its name instead of street and number.)

2. FULL NAME *Infant Hill*

(a) Residence. No. *St.*
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

1. SEX *Female*
4. COLOR OR RACE *White*
5. Single, Married, Widowed, or Divorced (write the word)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) *Jan 12 / 1930*
7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

10. NAME OF FATHER *O. Hill*
11. BIRTHPLACE OF FATHER (city or town) (State or Country) *Washington*
12. MAIDEN NAME OF MOTHER *Shepard*
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) *Missouri*

14. Informant *P. J. Heilly*
(Address) *Paola Wash*

15. Filed *Jan 14, 1930* *E. J. Thompson* Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Jan 12 1930*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Jan 12*, 19*30*, to *Jan 12*, 19*30*, that I last saw him alive on *Jan 12*, 19*30*, and that death occurred, on the date stated above, at *1 A* m. The CAUSE OF DEATH* was as follows:

Still Born.

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) *E. H. Hill* M. D.
Jan 12, 1930 (Address) *Paola Wash*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal *Paola Ida* Date of Burial *Jan 13 1930*

20. Undertaker *E. M. Duvin* Address *Paola Wash*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Nez Perce
City of Lewiston
No. 546-220037-736 St.

St. Josephs
(If born in hospital or institution
give name.)

FULL NAME OF CHILD

Registration District No. 96 State File No. S 178355
Prim, Registration District No. 1009 Local Registrar's No. Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female Twin Triplet or other? and Number in order of birth 5th Legitimate? Yes Date of birth Jan. 20 1930
(To be answered only in event of plural births) (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 5th (a) Born alive and now living Three
Born alive but now dead One Stillborn One

FATHER
FULL NAME Walter Willis Edwards
Residence (Usual place of abode) 1240 Idaho St
If non-resident, give place and State Lewiston Ida
Color or race White Age at last Birthday 41 (Years)
Birthplace Iowa
(City and State or County)
Occupation Laborer

MOTHER
FULL MAIDEN NAME Marie George
Residence (Usual place of abode) 1240 Idaho St
If non-resident, give place and State Lewiston Ida
Color or race White Age at last Birthday 32 (Years)
Birthplace Missn
(City and State or County)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 11:30 P. M.
on the date above stated.

(Signature) W. O. Clark
(Physician or midwife)

Address Lewiston Ida

Filed Jan 1 1930 Susan E Bruce
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

... presence of life after birth. ... whether not

.....
 Address
 Title
 Registrar.....

 (Physician or midwife)

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69307

PLACE OF DEATH

County of New PinedaleCity of LewistonRegistration District No. 9.6Primary Registration District No. 1009(No. St Joseph Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 7062. FULL NAME Wilma Jean Edwards(a) Residence. No. 124 of Idaho St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) 1/21/1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston Idaho
(State or country)10. NAME OF FATHER W. C. Edwards11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)12. MAIDEN NAME OF MOTHER Maie George13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)14. Informant W. C. Edwards
(Address) Lewiston Idaho.15. Filed Jan 1, 1930 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 21st 1930
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 21, 1930, to Jan 21, 1930
that I last saw him alive on Jan 21, 1930and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:Still Born

(duration) yrs. mos. ds.

CONTRIBUTORY Unknown
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. C. Clark M. D.1/22, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Lewiston Idaho 1/23 1930

Undertaker Address

Brown - Wm C Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

SP 78574

County of Ada
City of Boise
No. 1726 Howe St.

439.215-01-416
(If born in hospital or institution
give name.)

Registration District No. 2 State File No. 1864
Prim. Registration District No. 1864 Local Registrar's No. 88

FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other?	{ and }	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>2 - 15 - 1930</u> (Month) (Day) (Year)
----------------------------	------------------------------	---------	--------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth. 6 (a) Born alive and now living 5
Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>Leonard E. Ulrich</u>	MOTHER FULL MAIDEN NAME <u>Charlotte Moore</u>
--	---

Residence (Usual place of abode) 1726 Howe St. So. Boise
If non-resident, give place and State

Color or race White Age at last Birthday 42 (Years)
Birthplace New York (City and State or County)

Occupation Laborer
Color or race White Age at last Birthday 43 (Years)
Birthplace Minnesota (City and State or County)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 2:45 A.M.
on the date above stated.

(Signature) J. N. Brastang M.D.
Physician
(Physician or midwife)

Address Boise Idaho
Filed 2-17-30 W. H. Rhodes
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF NEW YORK
 DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS

County of _____
 City of _____
 State of New York

Registration District No. _____
 Local Health District No. _____
 (If different, specify the word "different" for name of child)

NAME OF CHILD _____
 SEX _____
 DATE OF BIRTH _____
 PLACE OF BIRTH _____
 (Month) (Day) (Year)

Was the child born to a mother who was living at the time of birth? _____
 (If not, specify the name of the mother and the date of death)

FATHER _____
 MOTHER _____
 NAME _____
 FULL NAME _____
 (Last name and first name)

Place of birth (Last place of birth) _____
 (If born in New York, specify the county and city or town)

Color of hair _____
 Color of eyes _____
 Birthplace _____
 (If born in New York, specify the county and city or town)

CERTIFICATE OF ATTENDANCE FOR PHYSICIAN OR MIDWIFE
 (If the child was attended by a physician or midwife, specify the name and the date of attendance)

Signature of _____
 (If the child was attended by a physician or midwife, specify the name and the date of attendance)

Signature of _____
 (If the child was attended by a physician or midwife, specify the name and the date of attendance)

Signature of _____
 (If the child was attended by a physician or midwife, specify the name and the date of attendance)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back.

RECEIVED MAR 11 1930
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 69410

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004
(No. 1726 Boise)

Local Registrar's No. 48

2. FULL NAME

(a) Residence No. Boise, Idaho St.
(Usual place of abode.)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Ida.
(State or country)

10. NAME OF FATHER Leonard E. Ulrich

11. BIRTHPLACE OF FATHER (city or town) New York
(State or Country)

12. MAIDEN NAME OF MOTHER Charlotte Moore

13. BIRTHPLACE OF MOTHER (city or town) Minn.
(State or Country)

14. Informant L. E. Ulrich.
(Address)

15. Filed 2-15-30 U. A. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1930 to Feb 15 1930
that I last saw him at Stillborn 1930
and that death occurred, on the date stated above, at 2:45 am

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH was as follows:

Probably Electrical shock of Mother about two weeks ago

(duration) yrs. mos. ds.
CONTRIBUTORY Don't know
(Secondary) Macerated Fetus
(duration) yrs. mos. ds.

18. Where was disease contracted Place of death
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) J. N. Brantley, M. D.
Feb 15 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal Date of Burial
C. M. Ulrich place 2-15-1930

20. Undertaker Barber Road Address
R. E. Ulrich 1726 Howe

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Saleman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile Factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home**, who are engaged in the duties of the household only (not paid House-keepers, who receive a definite salary), may be entered as **Housewife, Housework, or At Home**, and children not gainfully employed, as **At school or At Home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)**. For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia**; **Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.**, **Carcinoma, Sarcoma, etc.**, of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping Cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia," (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD—
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

County of Boise RECEIVED MAR 11 1930 DEPARTMENT OF PUBLIC WELFARE
City of Boise BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. 71 Registration District No. 2 State File No. 78591
(If born in hospital or institution give name) John Thomas Hap Prim. Registration District No. 1004 Local Registrar's No. 71FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>1 - 26 - 1930</u> (Month) (Day) (Year)
--------------------------	---	-------	--------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME <u>Albino Savala</u>	FULL MAIDEN NAME <u>Pilar Navaran</u>		
Residence (Usual place of abode) <u>303 Bannock St.</u>	Residence (Usual place of abode) <u>303 Bannock St.</u>		
If nonresident, give place and State	If nonresident, give place and State		
Color or race <u>White</u> Age at last Birthday <u>40</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>38</u> (Years)		
Birthplace <u>Spain</u> (City and State or Country)	Birthplace <u>Spain</u> (City and State or Country)		
Occupation <u>Shepherd</u>	Occupation <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at P. 30 A. M.
on the date above stated. { Stillborn }(Signature) I. M. Brayton M.D.
Physician
(Physician or midwife)

{ *Where there was no attending physician or midwife, then the father/householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }

Address Boise Idaho
Filed 2-10 1930 W. H. Rhodes
Registrar.

IN REPLY TO
STATEMENT OF PRINCIPAL
AND ASSISTANT PRINCIPAL

1. The principal of the school is
Mr. J. H. Smith, who is
a native-born American citizen
and a member of the Methodist
Church. He has been principal
of the school for the past
five years. He is a man of
high character and ability,
and is well qualified to
manage the school.

2. The assistant principal is
Mr. W. H. Jones, who is
also a native-born American
citizen and a member of the
Methodist Church. He has
been assistant principal for
the past three years. He is
a man of high character and
ability, and is well qualified
to assist the principal in
managing the school.

3. The school is a public
school, and is open to all
children of the community.
The school is a day school,
and the children attend from
8 o'clock in the morning to
4 o'clock in the afternoon.
The school is a free school,
and no tuition is charged.

4. The school is a
single-sex school, and only
boys are admitted. The
school is a primary school,
and the children are from
6 to 12 years of age.

5. The school is a
well-kept school, and the
buildings are in good
condition. The school is
a well-organized school,
and the children are well
taught. The school is a
well-known school, and the
children are well-liked.
The school is a well-
run school, and the
principal and assistant
principal are well-qualified
to manage the school.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 5 1930
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68982

County of Ada
City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 32

(No. St. Alphonsus Mrs)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Sabala

(a) Residence. No. 302 W. 1st St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) —

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 26 - 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Still born

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Ida
(State or country)

10. NAME OF FATHER Albino Sabala

11. BIRTHPLACE OF FATHER (city or town) Spain
(State or Country)

12. MAIDEN NAME OF MOTHER Pilar Haveran

13. BIRTHPLACE OF MOTHER (city or town) Spain
(State or Country)

14. Informant Albino Sabala
(Address) Boise, Ida

15. Filed 1-30-30 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Born dead
Malnourished & thin Jan 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Jan 26 1930, to Jan 26 1930
that I last saw him alive on never 19

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Several days before birth
Probably hypertension
of Mother & premature
loosening of Placenta
(duration) yrs. mos. ds. 7

CONTRIBUTORY
(Secondary) Mother Hypertension of
(duration) yrs. mos. ds. unknown

18. Where was disease contracted Boise Idaho
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. H. Brayton M. D.

Jan 27, 1930 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St. John's Cemetery
Date of Burial 1/28 1930

20. Undertaker Schneiter & W. Baum
Address Boise, Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

313-22003553 de 22003553
PLACED IN FILE MAR 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 178632

County of Sanwich
City of Pocatello

No. Pocatello 1111 St.

(If born in hospital or institution
give name.)

Registration District No. 28 State File No. 178632

Prim. Registration District No. 2/41 Local Registrar's No. 9674

FULL NAME OF CHILD (Stillbirth) Call
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u></u>	and {	Number in order of birth <u></u>	Legitimate? <u>yes</u>	Date of birth <u>Feb 20</u> 19 <u>30</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 1 Stillborn 1

FATHER	MOTHER
FULL NAME <u>Phillips C. Call</u>	FULL MAIDEN NAME <u>Hazel Nelson</u>
Residence (Usual place of abode) <u>Pocatello, Ida</u>	Residence (Usual place of abode) <u>Pocatello Ida</u>
If non-resident, give place and State <u>Brigham Utah</u>	If non-resident, give place and State <u>Brigham Utah</u>
Color or race <u>White</u> Age at last Birthday <u>26</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>26</u> (Years)
Birthplace <u>Charterfield Ida</u> (City and State or County)	Birthplace <u>Richfield Utah</u> (City and State or County)
Occupation <u>Dentist</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 10:32 P. M. on the date above stated.

(Signature) W. J. Groves

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Pocatello
Filed 11 30 1930 Registrar W. J. Groves

There was no attending physician
 present when the latter, deceased,
 died. He was a resident of the
 city of New York. A bill of
 exchange was drawn on the
 latter by the former, and the
 same was cashed at the bank of
 New York.

on the 1st day of May 1900
 at New York City

I, the undersigned, being a competent
 witness, do hereby certify that I attended the latter, deceased,
 at the time of his death, and that he died of natural causes.

TESTIMONY OF THE WITNESS

Subscribed and sworn to before me this 1st day of May 1900
 at New York City

Notary Public for the State of New York

My Commission Expires the 1st day of May 1901

Witness my hand and seal this 1st day of May 1900

at New York City

Notary Public for the State of New York

My Commission Expires the 1st day of May 1901

Witness my hand and seal this 1st day of May 1900

at New York City

Notary Public for the State of New York

RECEIVED MAR 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69434

PLACE OF DEATH

County of *Bannock*City of *Pocatello*Registration District No. *2*Primary Registration District No. *161*(No. *Pocatello, Id.*)Local Registrar's No. *5766*

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME *Infant Call*(a) Residence. No. *102 Brunscopts*

(Usual place of abode)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*4. COLOR OR RACE *White*5. Single, Married, Widowed, or Divorced (write the word) *Single*

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) *Feb 20, 1930*

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) *Pocatello*
(State or country) *Idaho*10. NAME OF FATHER *Philip C. Call*11. BIRTHPLACE OF FATHER (city or town) *Chesterfield, Ida.*
(State or Country)12. MAIDEN NAME OF MOTHER *Agnes Nelson*13. BIRTHPLACE OF MOTHER (city or town) *Chesterfield, Utah*
(State or Country)14. Informant *Phillip C. Call*(Address) *Pocatello, Idaho*15. Filed *Feb 20, 1930*

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Feb 20, 1930*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*2-20, 1930, to 2-20, 1930*that I last saw *her* alive on *2-20, 1930*and that death occurred, on the date stated above, at *9:30 PM*

The CAUSE OF DEATH* was as follows:

Premature (7 mo)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary) *Abruptio placentae*

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date of *-*Was there an autopsy? *No*What test confirmed diagnosis? *Wm. Brochers*(Signed) *Feb 20, 1930* (Address) *Pocatello*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Pocatello, Idaho Feb 21, 1930

20. Undertaker

Address

H. L. McHan Pocatello

206

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACED RECORD
County of Bannock MAR 12 1930
City of Pocatello
No. 5425 Griffith

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 178651

Registration District No. 28 State File No. 2
Prim. Registration District No. 2161 Local Registrar's No. 9655
(If born in hospital or institution give name.)
FULL NAME OF CHILD Stillbirth McFarland
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u>—</u>	and	Number in order of birth <u>—</u>	Legitimate <u>yes</u>	Date of birth <u>Feb 2 1930</u> (Month) (Day) (Year)
--------------------------	---------------------------------	-----	-----------------------------------	-----------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME <u>Charles M. McFarland</u>	FULL MAIDEN NAME <u>Beulah Maggie Hargraves</u>		
Residence (Usual place of abode) <u>Pocatello</u>	Residence (Usual place of abode) <u>Pocatello</u>		
If non-resident, give place and State <u>—</u>	If non-resident, give place and State <u>—</u>		
Color or race <u>white</u> Age at last Birthday <u>37</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>20</u> (Years)		
Birthplace <u>Yakima Wash.</u> (City and State or County)	Birthplace <u>Inkom, Ida.</u> (City and State or County)		
Occupation <u>Dr.</u>	Occupation <u>House wife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 8 P. M. on the date above stated.

(Signature) C. B. Groom
Physician
(Physician or midwife)

Address Pocatello, Idaho

Filed 3/11/30 1930
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

There was no attempt to
obtain the name of the
person who was the
subject of the letter.
The letter was dated
the 1st of May 1944.

I have not seen the letter
of the 1st of May 1944.

UNITED STATES OF AMERICA
DEPARTMENT OF JUSTICE

WASHINGTON, D. C.
MAY 1, 1944

RECEIVED
MAY 1, 1944

UNITED STATES OF AMERICA
DEPARTMENT OF JUSTICE

WASHINGTON, D. C.
MAY 1, 1944

RECEIVED
MAY 1, 1944

UNITED STATES OF AMERICA
DEPARTMENT OF JUSTICE

WASHINGTON, D. C.
MAY 1, 1944

RECEIVED
MAY 1, 1944

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
 Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
 and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
 tion is very important. See instruction on back of certificate.

RECEIVED FEB 14 1930
 PLACE OF DEATH

STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 63049

County of Bannock

City of Pocatello

Registration District No.

Primary Registration District No. 161
 (No. Pocatello General Hospital)

Local Registrar's No. 726

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jack McFarland

(a) Residence. No. Pocatello, Idaho. St.

(Usual place of abode)
 Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
 HUSBAND of
 (or) WIFE of

6. DATE OF BIRTH (month, day and year) February 2, 1930.

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Still Born

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello, Idaho.
 (State or country)

10. NAME OF FATHER Charles M. McFarland

11. BIRTHPLACE OF FATHER (city or town)
 (State or Country) Washington

12. MAIDEN NAME OF MOTHER Boulah M. Hargrave

13. BIRTHPLACE OF MOTHER (city or town)
 (State or Country) Inkom, Idaho.

14. Informant Charles M. McFarland
 (Address) 542 South Garfield Ave. Poca. Ida.

15. Filled 2/4, 1930 Registrar [Signature]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 2, 1930.

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2/2 1930, to 2/2 1930
 that I last saw him alive on 2/2 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Still Born.

(duration) yrs. mos. ds.

CONTRIBUTORY
 (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
 if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [Signature], M. D.
2/3/1930, 19 (Address) Poca. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial
Mountain View Cemetery 2/3/30. 19

20. Undertaker Arthur W. Hall Address Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

319 102 003 1332

PLACE OF BIRTH

County of BECE MAR 12 1930

City of Pocatello

No. 284-Washington-Res.

Pocatello, Ind.

(If born in hospital or institution give name.)

Registration District No. 28 State File No. 178652

Prim. Registration District No. 2161 Local Registrar's No. 96574

FULL NAME OF CHILD

Steelbirth Larsen

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>Feb. 2</u> 19 <u>30</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 6 (a) Born alive and now living 5

Born alive but now dead _____ Stillborn _____

FATHER
FULL NAME Carl Oscar Larsen

Residence (Usual place of abode) Pocatello, Ida

If nonresident, give place and State " "

Color or race White Age at last Birthday 46
(Years)

Birthplace Sweeden
(City and State or Country)

Occupation Foreman

MOTHER
FULL MAIDEN NAME Hanna Marie Olson

Residence (Usual place of abode) Pocatello, Ida

If nonresident, give place and State " "

Color or race White Age at last Birthday 42
(Years)

Birthplace Omakah, Neb.
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 1:45 P. M. on the date above stated.

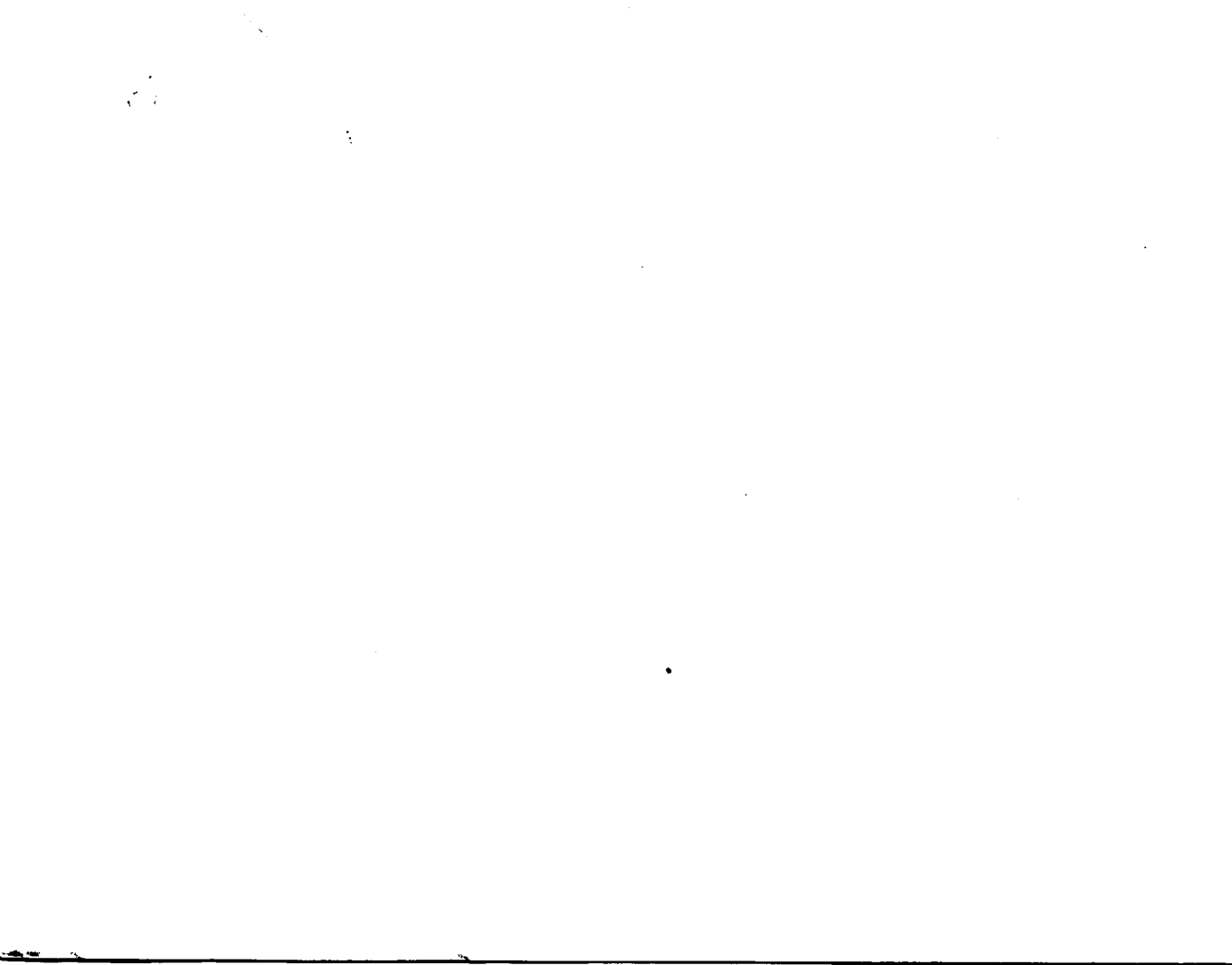
(Signature) D. C. Ray

(Physician or midwife)

Address Pocatello

Filed 3/1 1930 W. H. Manning
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

415-211-003-165
PLACE OF BIRTH Barre, Vt. MAR 12 1930
County of Barre
City of Pocatello
No. 2 St. Poc. Gen. Hospital
(If born in hospital or institution give name.)
Registration District No. 28 State File No. 178664
Prim. Registration District No. 2161 Local Registrar's No. 9642
FULL NAME OF CHILD Stillbirth Daniels (Vera Betty)
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female Twin Triplet or other? — and Number in order of birth — Legitimate? Yes Date of birth Jan 11 1930
(To be answered only in event of plural births) (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Escart La Mar Daniels
Residence (Usual place of abode) Pocatello
If nonresident, give place and State —
Color or race White Age at last Birthday 25 (Years)
Birthplace Malad, Idaho
(City and State or Country)
Occupation Stockman

MOTHER
FULL MAIDEN NAME Vera Betty Jones
Residence (Usual place of abode) Pocatello
If nonresident, give place and State —
Color or race White Age at last Birthday 20 (Years)
Birthplace Salt Lake City, Utah
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

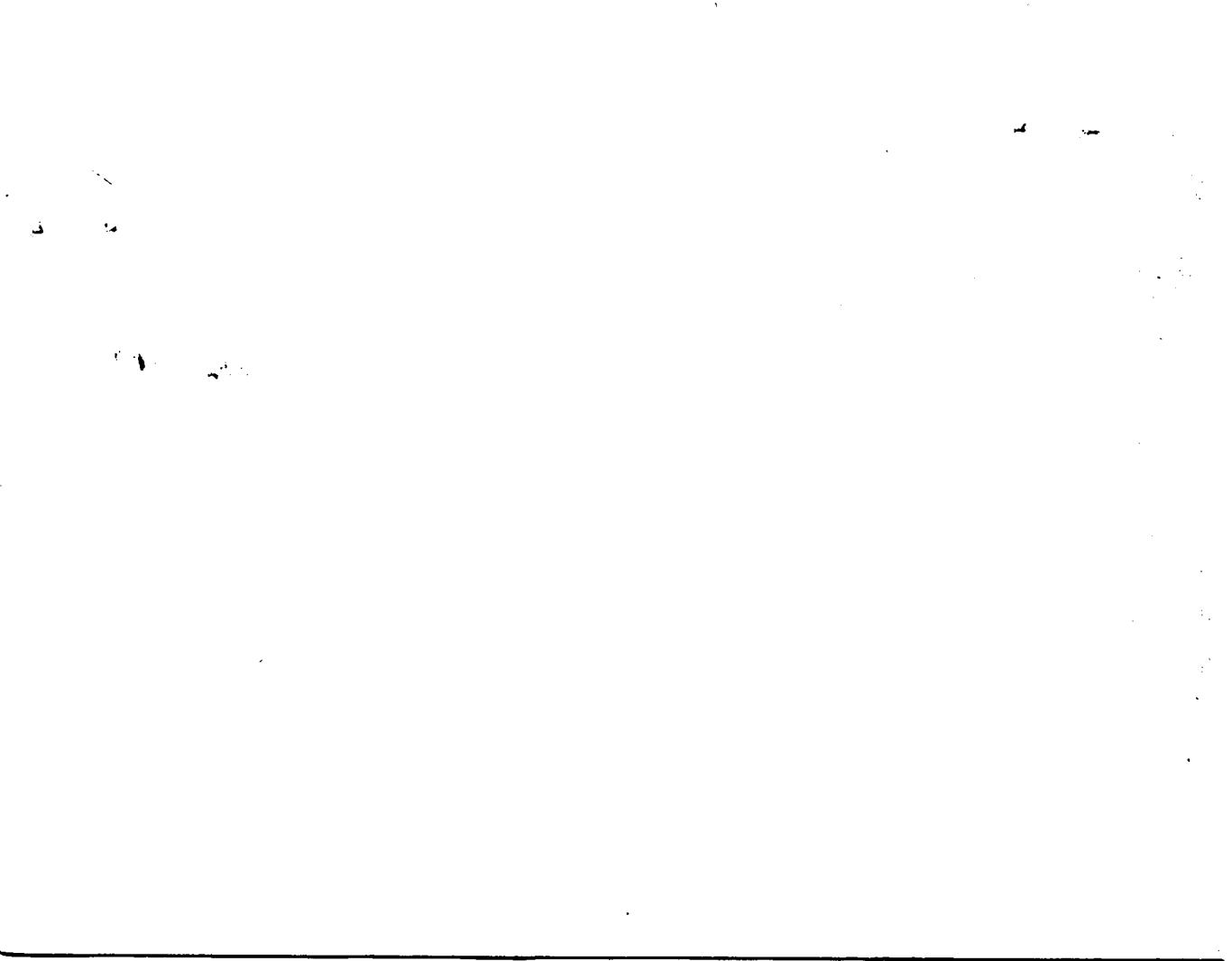
I hereby certify that I attended the birth of this child, who was Born alive at 3:50 P. M.
on the date above stated. Stillborn

(Signature) D. F. Ray
(Physician or midwife)

Address Pocatello

Filed 3/1 1930 Ray
Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69037

PLACE OF DEATH

County of BannockCity of PocatelloRegistration District No. 28Primary Registration District No. 2161(No. Pocatello General Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 57412. FULL NAME Infant Daniels(a) Residence. No. Pocatello, Idaho. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX

Female

4. COLOR OR RACE

White

5. Single, Married, Widowed, or Divorced (write the word)

Single

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) January 11, 1930

7. AGE

Years

Months

Days

If LESS than 1 day,

Still Bornhrs. or
min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello, Idaho.
(State or country)

10. NAME OF FATHER

Lamar Daniels11. BIRTHPLACE OF FATHER (city or town)
(State or Country)Malad, Idaho,

12. MAIDEN NAME OF MOTHER

Vera Betty Jones13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)Idaho.14. Informant Lamar Daniels

(Address)

Pocatello, Idaho.

15. Filed

1-12-3019 30

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 11, 1930.

(Month)

(Day)

19 30
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 30, to 1-11, 19 30that I last saw him alive on _____, 19 30

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Died in uterus 2 days
from high pressure on cord.

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) D. G. Ray, M. D.19 30 (Address) Pocatello
Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Malad, Idaho.1/13/30 19 30

20. Undertaker

Address

ARTHUR W. HALLPOCATELLO

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH Blaine MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 178726

County of Blaine
City of Lary
No. 135116-1117-219 St. ---

Registration District No. 57 State File No. ---

(If born in hospital or institution
give name.)

Prim. Registration District No. 2025 Local Registrar's No. 9

FULL NAME OF CHILD Milo Eugene Atwood (Stillborn)
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>---</u> and <u>---</u> Number in order of birth <u>---</u>	Legitimate? <u>Yes</u>	Date of birth <u>2-16-1930</u> (Month) (Day) (Year)
--------------------------	--	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? ---

Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead --- Stillborn 1

FATHER
FULL NAME Alvin Eugene Atwood
Residence (Usual place of abode) Lary, Idaho
If nonresident, give place and State ---
Color or race White Age at last Birthday 23 (Years)
Birthplace Bozeman, Idaho
(City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Mary Elizabeth Briggs
Residence (Usual place of abode) Lary, Idaho
If nonresident, give place and State ---
Color or race White Age at last Birthday 24 (Years)
Birthplace Spanish Fork, Utah
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 10:30 a M.
on the date above stated.

(Signature) E. W. Fox
Physician
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Blaine, Idaho
Filed 3-1-30 C. E. H. Wright
Registrar

20

21

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 13 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69472

County of Laine
City of Larey

Registration District No. 57
Primary Registration District No. 12025

Local Registrar's No. 7

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wm. Eugene Atwood

(a) Residence No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
6a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u> </u>		
6. DATE OF BIRTH (month, day and year) <u>Still born</u>		
7. AGE Years <u> </u>	Months <u> </u>	Days <u> </u> LESS than 1 day, <u> </u> hrs. or <u> </u> min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u> </u> (b) General nature of industry, business, or establishment in which employed (or employer) <u> </u> (c) Name of employer <u> </u>		

9. BIRTHPLACE (city or town) Larey, Idaho
(State or country)

10. NAME OF FATHER <u>Alvin Eugene Atwood</u>
11. BIRTHPLACE OF FATHER (city or town) (State or Country) <u>Reynoldsburg, Idaho</u>
12. MAIDEN NAME OF MOTHER <u>Mary Elizabeth Briggs</u>
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) <u>Reynoldsburg, Idaho</u>

14. Informant Alvin E. Atwood
(Address) Larey, Idaho

15. Filed 2-1, 1930 Robert H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
2 / 16 / 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 , that I last saw him alive on , 19 , and that death occurred, on the date stated above, at 10:30 a.m.
The CAUSE OF DEATH* was as follows:

Still born - Full term
Placental Abnormalities
Preceding birth - marginal
Placental Abnormalities

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical

(Signed) , M. D.
2/17, 1930. (Address) Larey, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal <u>Larey, Ida</u>	Date of Burial <u>2-17</u> 19 <u>30</u>
20. Undertaker <u> </u>	Address <u> </u>

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLA RECEIVED MAR 7 1930

County of Bonner
City of Sandpoint
No. 299713009766 St.
Parnell Hosnital
(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 178737

Registration District No. 76 State File No. _____
Prim. Registration District No. 2155 Local Registrar's No. 22
Stillbirth

FULL NAME OF CHILD _____
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twins or other? <u>Triplets</u>	and	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>February 13</u> <u>1930</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Silver Nitrate 1st

Number of child of this mother, including present birth 5th (a) Born alive and now living Four
Born alive but now dead _____ Stillborn One

FATHER	MOTHER
FULL NAME <u>Earl Brittain</u>	FULL MAIDEN NAME <u>Kathleen Powers</u>
Residence (Usual place of abode) <u>Dover, Idaho.</u>	Residence (Usual place of abode) <u>Dover, Idaho.</u>
If nonresident, give place and State _____	If nonresident, give place and State _____
Color or race <u>White</u> Age at last Birthday <u>33</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>29</u> (Years)
Birthplace <u>Seattle, Washington</u> (City and State or Country)	Birthplace <u>Rosslyn B.C. Canada</u> (City and State or Country)
Occupation <u>Telephone Operator</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

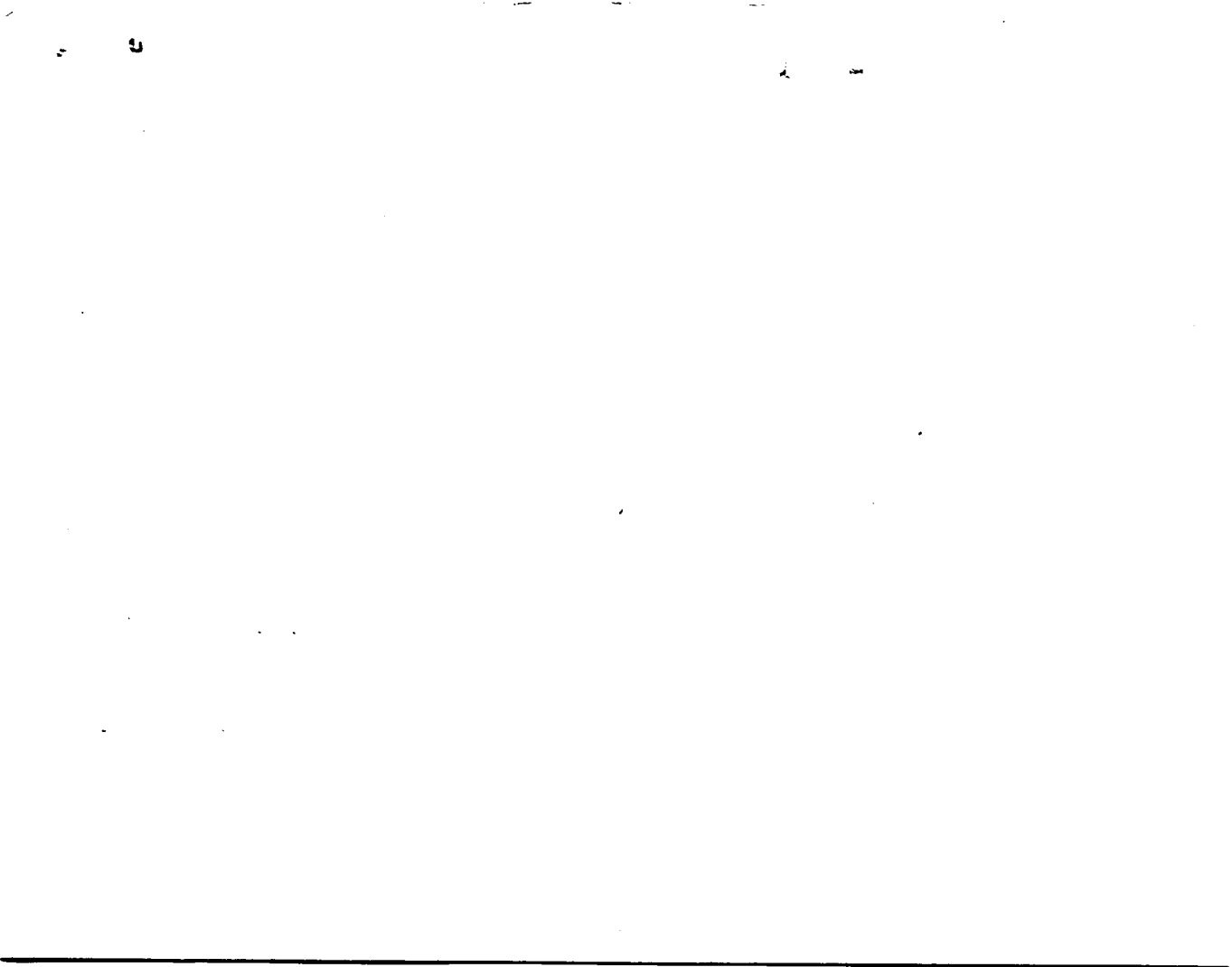
I hereby certify that I attended the birth of this child, who was Stillborn at 6.20 P.M. M.
on the date above stated.

(Signature) O. B. Evans
Physician
(Physician or midwife)

Address Sandpoint, Ida.

Filed Mar 3 1930 Viola Allen
Deputy Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 89481

PLACE OF DEATH

County of BonnerCity of SandpointRegistration District No. 78Primary Registration District No. 2155Local Registrar's No. 14

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Brittain

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. Single, Married, Widowed,
or Divorced, (write the word)
Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Feb. 15, 1930

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min. -

Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of workNone(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Sandpoint
(State or country) Idaho

10. NAME OF FATHER

Earl R. Brittain11. BIRTHPLACE OF FATHER (city or town)
(State or Country)Seattle Wash

12. MAIDEN NAME OF MOTHER

Kathleen Powers13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)Kearland B.C.14. Informant Earl R. Brittain

(Address)

Seattle Washington

15. Filed

Feb. 161930Viola Adlers
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb.151930

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 15th, 1930, to Feb. 15th, 1930

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

Still birth in 8th
month of gestation

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Placenta Praevia

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? No Date of _____Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

V. B. Goran, M. D.2 - 15th, 1930 (Address) Sandpoint*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Peace Cemetery, Feb. 16, 1930

20. Undertaker

Address

Moore Mortuary Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instruction on back of certificate.

PARENTS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED MAR 7 1930
County of Banner
City of Sandpoint
No. 724 N. Fresh Ave.
251 121 067 4436
(If born in hospital or institution give name.)
Registration District No. 76 State File No. 178738
Prim. Registration District No. 2153 Local Registrar's No. 212
FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimacy <u>yes</u>	Date of birth <u>2 21 1930</u> (Month) (Day) (Year)
--------------------------	---	---	-----------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? Silver Nitrate 1%

Number of child of this mother, including present birth Two (a) Born alive and now living 1

Born alive but now dead _____ Stillborn 1

FATHER FULL NAME <u>Mr. Eddie Beal</u>	MOTHER FULL MAIDEN NAME <u>Grace Moore</u>
---	---

Residence (Usual place of abode) Sandpoint

If nonresident, give place and State _____

Color or race White Age at last Birthday 22 (Years)

Birthplace Washington (City and State or Country)

Occupation Sign Painter

Color or race White Age at last Birthday 20 (Years)

Birthplace Dichigan (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {Born alive
Stillborn } at 9:30 P. M.
on the date above stated.

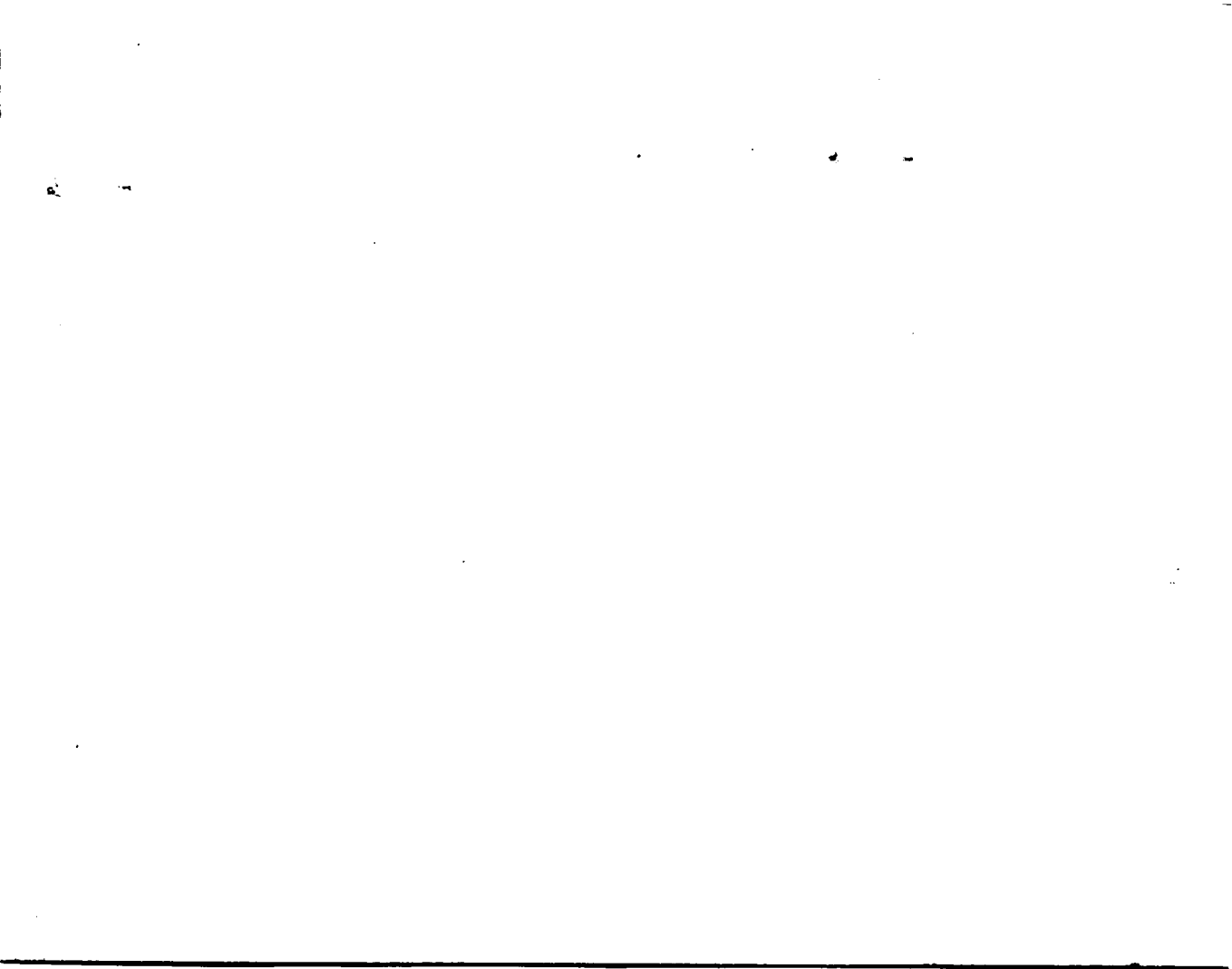
(Signature) Wm. L. Tyler

(Physician or midwife)

Address Sandpoint, Ida

Filed Mar 3 1930 Viola Allen
Deputy Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 7 1930
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
(No. 724 Forest Ave)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 606477

Local Registrar's No. 204

2. FULL NAME Stillborn Beal

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)
5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of
6. DATE OF BIRTH (month, day and year) Feb. 21, 1930
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillborn
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Sandpoint
(State or country) Idaho

10. NAME OF FATHER Gen Beal

11. BIRTHPLACE OF FATHER (city or town) St. Washington
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER Grace N. Moore

13. BIRTHPLACE OF MOTHER (city or town) Town of Pine
(State or Country) Michigan

14. Informant Mrs Ruth Flanagan
(Address) Sandpoint

15. Filed Feb. 22 1930
Hilda Allen
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Stillborn Feb 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21 1930 to Feb 21 1930
that I last saw him alive on Feb 21 1930

and that death occurred, on the date stated above, at 9:30 P.m.

The CAUSE OF DEATH* was as follows:

6 1/2 month foetus
still born. cause unknown
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm F. Tyler M. D.
Feb 22 1930 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Seneacquotess Co Date of Burial Feb. 22 1930

20. Undertaker Wade, Ida Address 911m Ruth Flanagan
Basile
Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

RECEIVED MAR 7 1930
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

178741

County of Bonner
City of Sandpoint, Ida.
No. 316-009-313 St.

Parnell Hospital Registration District No. 78 State File No. _____
(If born in hospital or institution give name.) Prim. Registration District No. 2153 Local Registrar's No. 18

FULL NAME OF CHILD Stillborn Bonnar
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>female</u>	Twin Triplet or other?	and	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Feb 16</u>	19 <u>30</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)	

What prophylactic was used to prevent Ophthalmia Neonatorum? Silver nitrate

Number of child of this mother, including present birth 3 (a) Born alive and now living 1

Born alive but now dead _____ Stillborn 2

FATHER FULL NAME <u>Charles Bonnar</u>	MOTHER FULL MAIDEN NAME <u>Essa Colville</u>
---	---

Residence (Usual place of abode) Sandpoint (Idaho) Residence (Usual place of abode) Sandpoint (Idaho)

If nonresident, give place and State _____ If nonresident, give place and State _____

Color or race White Age at last Birthday 40 Color or race White Age at last Birthday 29
(Years) (Years)

Birthplace Bellefonte W. Virginia Birthplace Trenton, Mo
(City and State or Country) (City and State or Country)

Occupation Farmer Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive } at 10:30 P. M.
on the date above stated. } Stillborn }

(Signature) Floyd E. Wendle
M.D.
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Sandpoint, Idaho

Filed Mar 3 1930 W. G. Allen
Deputy Registrar.

2
 117711
 CHARGE
 DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH
 State of New York
 County of Westchester
 City of New York
 Date of Birth
 Name of Child
 Sex of Child
 Color of Child
 Place of Birth
 Date of Birth
 Name of Father
 Name of Mother
 Name of Physician
 Name of Midwife
 Name of Nurse
 Name of Doctor
 Name of Hospital
 Name of Clinic
 Name of Office
 Name of Home
 Name of Street
 Name of City
 Name of State
 Name of Country
 Name of Continent
 Name of Ocean
 Name of Planet
 Name of Universe
 Name of Everything

2
 117711
 CHARGE
 DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH
 State of New York
 County of Westchester
 City of New York
 Date of Birth
 Name of Child
 Sex of Child
 Color of Child
 Place of Birth
 Date of Birth
 Name of Father
 Name of Mother
 Name of Physician
 Name of Midwife
 Name of Nurse
 Name of Doctor
 Name of Hospital
 Name of Clinic
 Name of Office
 Name of Home
 Name of Street
 Name of City
 Name of State
 Name of Country
 Name of Continent
 Name of Ocean
 Name of Planet
 Name of Universe
 Name of Everything

20. Undertaker	Address
Moon Mortuary	Seapoint

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACED ON FILE MAR 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

✓
S

County of Clearwater
City of Crofton, Idaho
No. _____ St. _____

255 217 018 255
(If born in hospital or institution give name.)

Registration District No. 90 State File No. 178885

Prim. Registration District No. 2157 Local Registrar's No. 20

FULL NAME OF CHILD Unnamed Benedict
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>Feb. 17</u> 19 <u>30</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 3 (a) Born alive and now living 1
Born alive but now dead 1 Stillborn 1

FATHER FULL NAME <u>Ezra B. Benedict Jr.</u>	MOTHER FULL MAIDEN NAME <u>Rattie Seech</u>
---	--

Residence (Usual place of abode) Crofton

If nonresident, give place and State _____

Color or race W Age at last Birthday 40 (Years)
Color or race W Age at last Birthday 44 (Years)

Birthplace Idaho (City and State or Country)
Birthplace Idaho (City and State or Country)

Occupation Rancher Occupation St. Louis

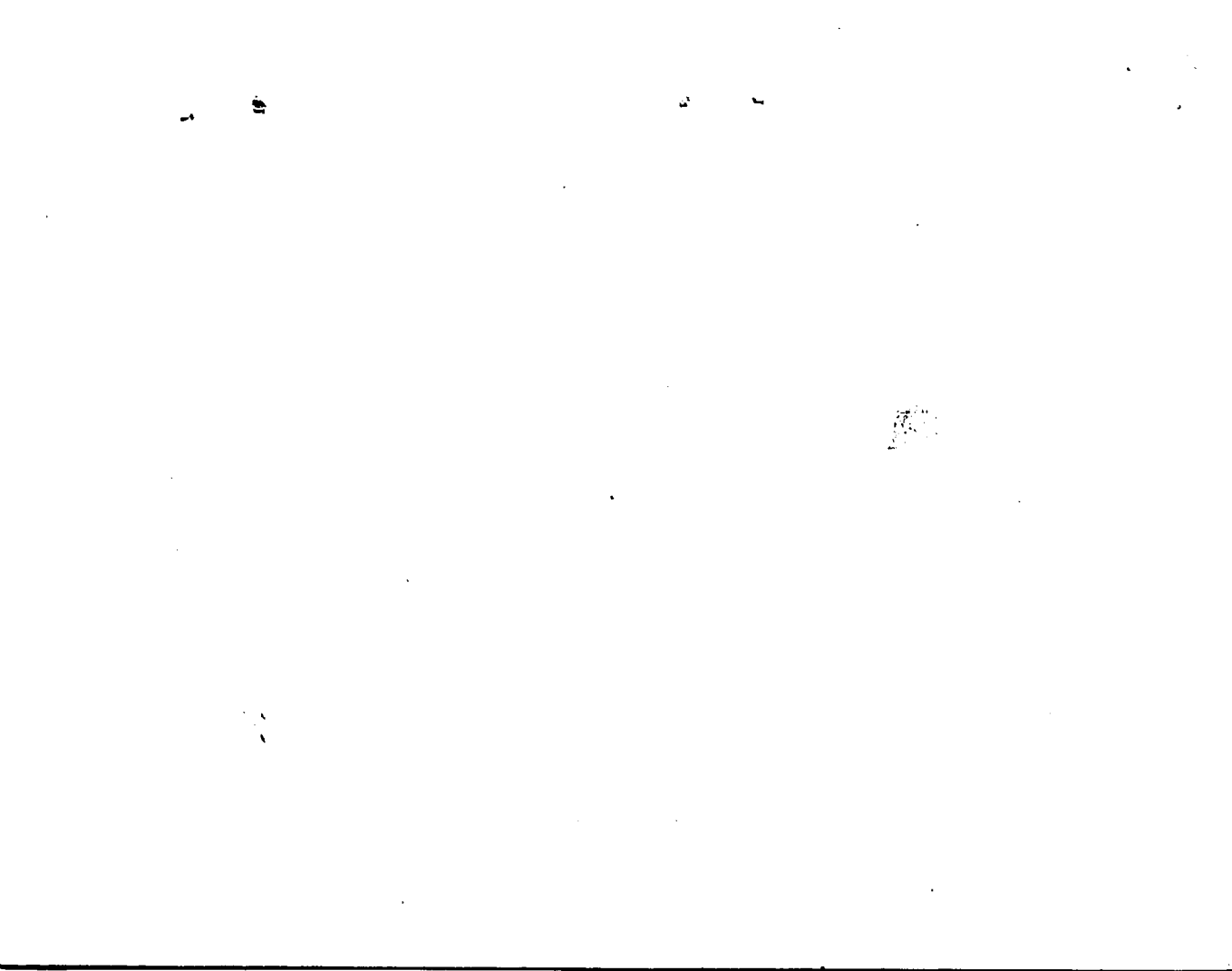
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 7:00 A. M.
on the date above stated. { Stillborn }

(Signature) E. B. Benedict Jr.
(Father)
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Crofton, Idaho
Filed 2/15 19 1930 H. E. Shann
Registrar.



1788854 WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC-
CUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 69551

PLACE OF DEATH

CERTIFICATE OF DEATH

Local Registrar's No. 18

County of Cassia Registration District No. 90

City of Proffins, Ida. Primary Registration District No. 2187

(No. _____)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Myranda Benedict

(a) Residence. No. Proffins, Ida. St. 706

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days If LESS than 1 day, ____ hrs. or ____ min. Fullborn

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) Proffins, Ida.
(State or country)

10 NAME OF FATHER Ezra B. Benedict Jr.

11 BIRTHPLACE OF FATHER (city or town) Minnesota
(State or country)

12 MAIDEN NAME OF MOTHER Hattie Seely

13 BIRTHPLACE OF MOTHER (city or town) Minnesota
(State or country)

14 Informant E. B. Benedict Jr.
(Address)

15 Filed 2/15, 1930 W.A. Shan
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

2 17 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,
that I last saw h. _____ alive on _____, 19____,
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____
Was there an autopsy? _____

What test confirmed diagnosis? _____
(Signed) Had no Doctor, M. D.
_____, 19____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Proffins Ida Date of Burial 2/19 1930

20. Undertaker W.A. Shan Address Proffins

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

County of 7. RECEIVED MAR 8 1930

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

City of Preston, Ida

CERTIFICATE OF BIRTH

No. 194-126-021-284 St.

Registration District No. 27 State File No. 178904

(If born in hospital or institution
give name.)

Prim. Registration District No. 2119 Local Registrar's No. 7

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other?	{ and {	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Feb. 26</u> 19 <u>30</u>
					(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth. 2 (a) Born alive and now living 1

Born alive but now dead. Stillborn 1

FATHER
FULL NAME Wm. J. Armstrong

MOTHER
FULL MAIDEN NAME Ida Shumway

Residence (Usual place of abode) Pocatello, Ida

Residence (Usual place of abode) Pocatello, Ida

If non-resident, give place and State

If non-resident, give place and State

Color or race White Age at last Birthday 28 (Years)

Color or race White Age at last Birthday 33 (Years)

Birthplace Idaho
(City and State or County)

Birthplace Idaho
(City and State or County)

Occupation Farmer

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 1:00 P. M.
on the date above stated.

(Signature) A. K. Quiler

(Physician or midwife)

Address Preston, Ida

Filed Feb. 27, 1930 A. K. Quiler

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

There were no attending physician or other persons in the household at the time of the death. A physician was called but he did not arrive until after the death.

I hereby certify that I attended the birth of this child, who was

DECLARATION OF ATTENDING PHYSICIAN OR MIDWIFE

Occupation

Address and name of family

Telephone

Color of hair

Color of eyes

Height of child at last birthday

Weight of child at last birthday

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1930

PLACE OF DEATH

County of Franklin
City of Preston Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 27
Primary Registration District No. 2119

DO NOT WRITE IN THIS SPACE
State File No. 69571

Local Registrar's No. _____

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

700

2. FULL NAME Stillborn

(a) Residence. No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. Single, Married, Widowed, or Divorced (write the word)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year) <u>Feb. 26, 1930</u>		
7. AGE Years	Months	Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (city or town) Preston, Idaho
(State or country)

10. NAME OF FATHER <u>Wm. J. Armstrong</u>
11. BIRTHPLACE OF FATHER (city or town) (State or Country) <u>Idaho</u>
12. MAIDEN NAME OF MOTHER <u>Ida Shumway</u>
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) <u>Idaho</u>

14. Informant Wm. J. Armstrong
(Address) Pocatello Idaho

15. Filed Feb. 27, 1930
G. H. Miller
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month) (Day) (Year) 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
that I last saw h_____ alive on _____, 19____
and that death occurred, on the date stated above, at _____m.
The CAUSE OF DEATH* was as follows:

Stillborn
Cause unknown
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death? _____
Did an operation precede death? _____ Date of _____
Was there an autopsy? _____
What test confirmed diagnosis? _____
(Signed) A. R. Cutler M. D.
Feb. 27, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Preston Ida Date of Burial 2-27 1930

20. Undertaker _____ Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

815-120-329-494

PLACE RECEIVED

MAR 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 178993

County of Idaho
City of Troy
No. _____ St. _____

Registration District No. 64 State File No. _____

(If born in hospital or institution
give name.)

From Registration District No. 2144 Local Registrar's No. _____

FULL NAME OF CHILD

Heberth Hanson

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- macy <u>yes</u>	Date of birth <u>Feb. 20</u> 19 <u>30</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------	-------------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth. 5th Born alive and now living 4

Born alive but now dead 0 Stillborn 1

FULL NAME <u>Henry John Hanson</u>	FATHER	FULL MAIDEN NAME <u>Mabel Dimmick</u>	MOTHER
--	--------	--	--------

Residence (Usual place of abode) Troy, Idaho

If non-resident, give place and State _____

Color or race White Age at last Birthday 35 (Years)

Birthplace Pennsylvania (City and State or County)

Occupation lumber mill operator

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 3:50 M.
on the date above stated.

(Signature) Chas. D. Meyer

(Physician or midwife)

Address Troy, Idaho

Filed Feb 28 1930 Lucy M. Pickard
Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

UNITED STATES
DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

Residence of _____
City _____ State _____
Date of Birth _____

Occupation _____
Date of _____
Place of _____
Date of _____

Place of _____
Date of _____
Place of _____
Date of _____

Place of _____
Date of _____
Place of _____
Date of _____

Place of _____
Date of _____
Place of _____
Date of _____

Place of _____
Date of _____
Place of _____
Date of _____

Place of _____
Date of _____
Place of _____
Date of _____

Place of _____
Date of _____
Place of _____
Date of _____

Place of _____
Date of _____
Place of _____
Date of _____

Place of _____
Date of _____
Place of _____
Date of _____

Place of _____
Date of _____
Place of _____
Date of _____

12

UNITED STATES

DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

Residence of _____
City _____ State _____
Date of Birth _____

Occupation _____
Date of _____
Place of _____
Date of _____

Place of _____
Date of _____
Place of _____
Date of _____

Place of _____
Date of _____
Place of _____
Date of _____

Place of _____
Date of _____
Place of _____
Date of _____

Place of _____
Date of _____
Place of _____
Date of _____

Place of _____
Date of _____
Place of _____
Date of _____

Place of _____
Date of _____
Place of _____
Date of _____

Where there was no attending physician
in the case of the deceased, a physician
should be called. A physician
should be called in the case of
a person who is ill or injured.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 6 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69611

County of Latah

Registration District No. 64

Local Registrar's No.

City of Troy

Primary Registration District No. 2144

(No. _____)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME (Still Birth) Hanson

(a) Residence. No. _____ St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days 1 If LESS than 1 day, 0 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Troy Ida (State or country)

10 NAME OF FATHER Henry John Hanson

11 BIRTHPLACE OF FATHER (city or town) Missouri (State or country)

12 MAIDEN NAME OF MOTHER Mildred Dimmick

13 BIRTHPLACE OF MOTHER (city or town) Penn (State or country)

14 Informant H. J. Hanson (Address) Troy Ida

15 Filed Feb 20, 1930 Lucy M. Pickard Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 20, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1930, to Feb. 20, 1930, that I last saw him alive on Still Birth, 1930, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH was as follows:

Still Birth
asphyxia (breach presentation). (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of _____

Was there an autopsy?

What test confirmed diagnosis? (Signed) Geo. Q. Meyer, M.D. Feb 20, 1930 (Address) Troy, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Healdala cem Date of Burial Feb 20 1930

20. Undertaker John J. Pickard Address Troy Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

551-115030-436

PLACE STAMP RECEIVED FEB 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 179011

County of Blaine
City of Carmen
No. _____ St. _____

Registration District No. 41 State File No. _____

(If born in hospital or institution
give name.)

Prim. Registration District No. 2116 Local Registrar's No. _____

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>jk</u>	Date of birth <u>Jan 15</u> 19 <u>30</u> (Month) (Day) (Year)
--------------------------	---	-------	---	----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth one (a) Born alive and now living none

Born alive but now dead _____ Stillborn this one

FATHER
FULL NAME Ernest Neal

Residence (Usual place of abode) Carmen

If nonresident, give place and State _____

Color or race wh Age at last Birthday 28 (Years)

Birthplace Idaho (City and State or Country)

Occupation Ranchman

MOTHER
FULL MAIDEN NAME Katie McFarland

Residence (Usual place of abode) Carmen

If nonresident, give place and State _____

Color or race wh Age at last Birthday 18 (Years)

Birthplace Idaho (City and State or Country)

Occupation Pr

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 6 a. m.
on the date above stated. { Stillborn }

(Signature) Dr. Hugh H. S.

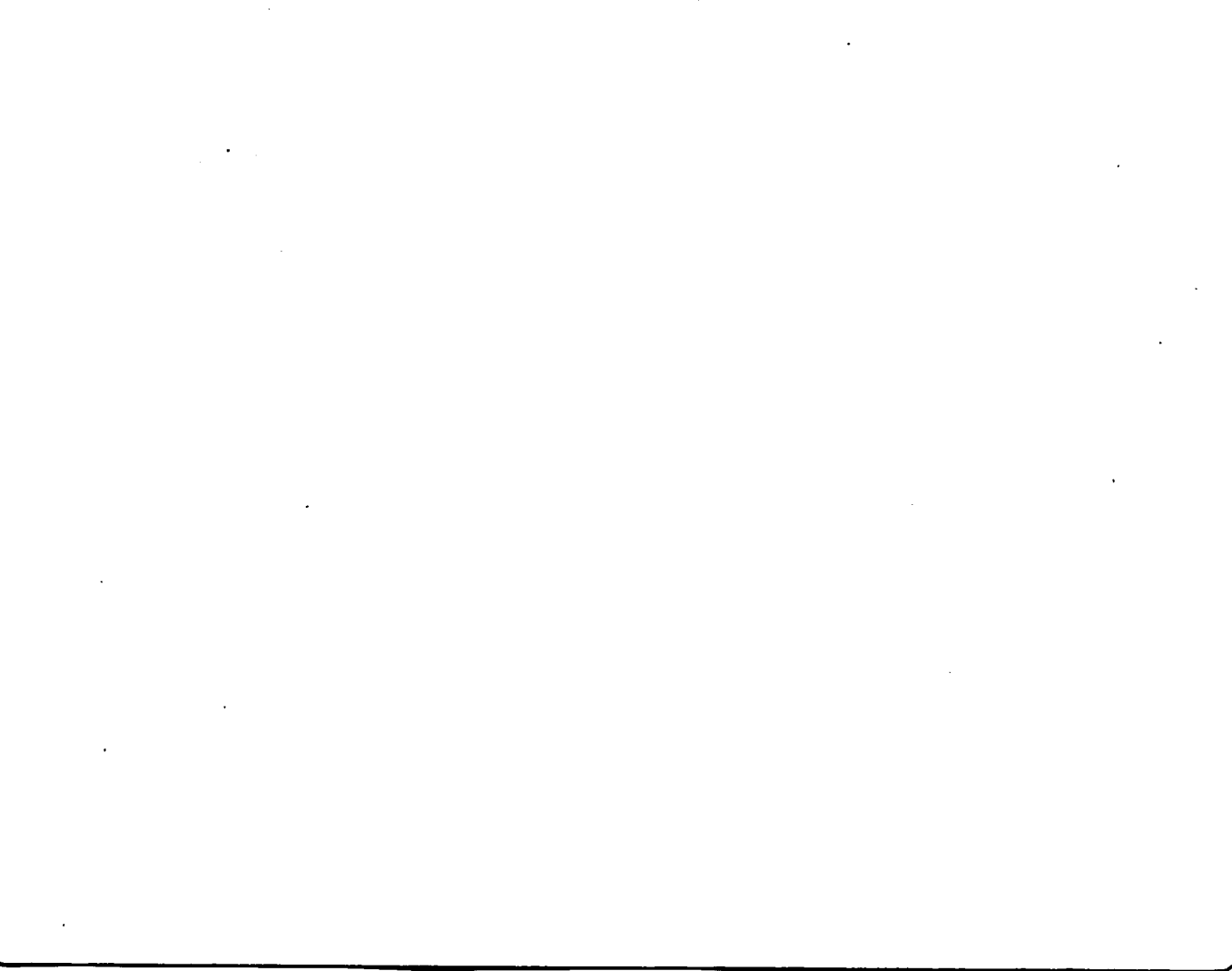
(Physician or midwife)

Address Calmar Ida

Filed Feb 11 1930 Cliff E. Bellamy

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED MAR 11 1930
County of Mundwisha STATE OF IDAHO
City of Paul DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH **S** 179042
No. 955-107034-366 St. Registration District No. 19 State File No. 179042
(If born in hospital or institution give name.) Prim. Registration District No. 2015 Local Registrar's No. 32

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>March 7</u> 19 <u>30</u> (Month) (Day) (Year)
--------------------------	---	-------	--------------------------------	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 1
Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME <u>Willis S. Reed</u>	FULL MAIDEN NAME <u>Mellie May Coon</u>		
Residence (Usual place of abode) <u>Paul Ida.</u>	Residence (Usual place of abode) <u>Paul Ida.</u>		
If nonresident, give place and State <u> </u>	If nonresident, give place and State <u> </u>		
Color or race <u>white</u> Age at last Birthday <u>30</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>30</u> (Years)		
Birthplace <u>Idaho</u> (City and State or Country)	Birthplace <u>Idaho</u> (City and State or Country)		
Occupation <u>Farmer</u>	Occupation <u>Housewife</u>		

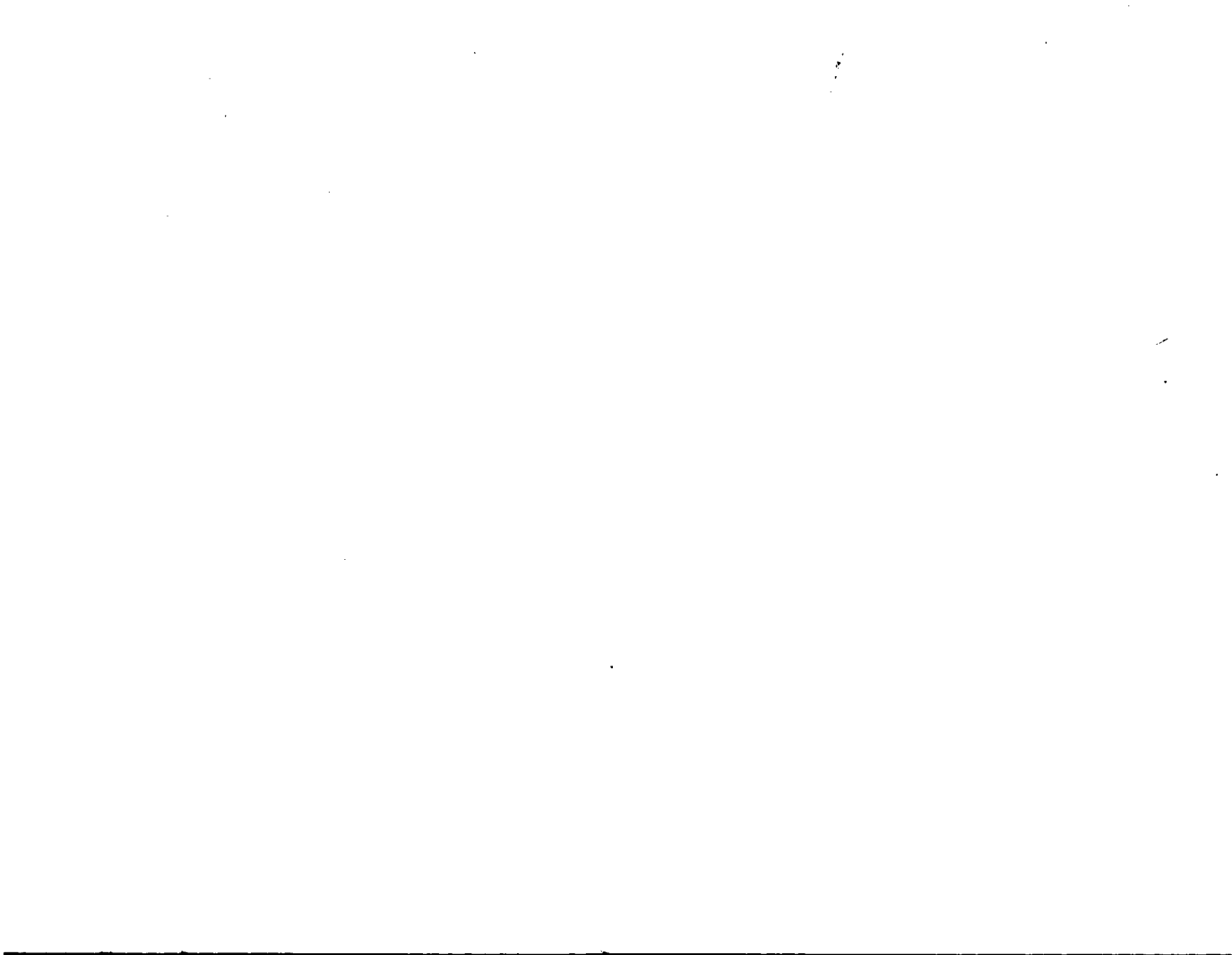
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 10 20 A. M.
on the date above stated. { Stillborn }

(Signature) E. D. Elmore
md.
(Physician or midwife)

Address Rupert, Idaho
Filed 3-9 1930 E. D. Elmore
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

433 114 042 432
PLACE OF BIRTH

County of Twin Falls **RECEIVED** MAR 10 1930

City of Twin Falls

No. _____ St. _____

T. F. Coyle
(If born in hospital or institution
give name.)

Registration District No. 87 State File No. 179150

Prim. Registration District No. 2082 Local Registrar's No. _____

FULL NAME OF CHILD _____
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? _____	and {	Number in order of birth _____	Legiti- mate? <u>Yes</u>	Date of birth <u>Feb 14</u> 19 <u>30</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth. 0 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME <u>Arthur T. McCree</u>	FULL MAIDEN NAME <u>Hope McKinley</u>

Residence (Usual place of abode) Kimberly Idaho Residence (Usual place of abode) Kimberly Idaho

If non-resident, give place and State _____ If non-resident, give place and State _____

Color or race W Age at last Birthday 24 (Years) Color or race W Age at last Birthday 24 (Years)

Birthplace Philipsburg, Kan (City and State or County) Birthplace Ocala, Fla (City and State or County)

Occupation laborer - coach Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 3 ⁴⁰ 0 M.
on the date above stated.

(Signature) J. W. Davis

(Physician or midwife)

Address Kimberly, Idaho

Filed 3-5-1930 Elizabeth Smith

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Q. Was there any other person present at the birth of the child?
A. Yes, there was a woman named Mary who was the mother of the child.
Q. Did you see the child at any other time?
A. Yes, I saw the child at the hospital when it was born.
Q. Did you see the child at any other time?
A. Yes, I saw the child at the hospital when it was born.

When there was no attending physician or midwife present the father or mother or some other person present at the birth of the child should make this return. A physician or midwife should make this return when there was an attending physician or midwife present at the birth of the child.

(Signature)

I hereby certify that I attended the birth of this child who was born on the _____ day of _____, 19____.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

Name of child

Sex and date of birth

Place of birth

Name of mother

Name of father

Address

City and State

County

State

Year

Month

Day

Hour

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 59690

PLACE OF DEATH

County of Twin Falls

City of 11 11

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No. O. Gene Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. Baby McCreary St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word)

Male White Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 14 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Twin Falls Ida. (State or country)

10. NAME OF FATHER Arthur F. McCreary

11. BIRTHPLACE OF FATHER (city or town) Idaho (State or Country)

12. MAIDEN NAME OF MOTHER Hope McCreary

13. BIRTHPLACE OF MOTHER (city or town) Don't know (State or Country)

14. Informant Arthur F. McCreary (Address) Kimberly Ida

15. Filed 2-6 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 - 14 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-14 1930 to 2-14 1930

that I last saw him alive on Stillborn 1930

and that death occurred, on the date stated above, at 3 9, m.

The CAUSE OF DEATH* was as follows:

Intra-uterine Strangulation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. J. Doerns M. D.

2/14 1930 (Address) Kimberly Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Funerary Feb. 15 1930

20. Undertaker Address

J. J. Doerns Twin Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFAADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

County of Valley
City of Cascade

No. 847-211043-135 St. 135

(If born in hospital or institution give name.)

Registration District No. 25

State File No. 179189

Prim Registration District No. Stillborn - Infant Hughes

Local Registrar's No. 2

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child

Female

Twin
Triplet
or other?
(To be answered only in event of plural births)

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

Feb 11
(Month) (Day)

1930
(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 7

(a) Born alive and now living 2

Born alive but now dead 0

Stillborn 2

FULL
NAME

FATHER
Rufus A. Hughes

FULL
MAIDEN
NAME

MOTHER
Zadie Carrie Allen

Residence (Usual place of abode)

Cascade

Residence (Usual place of abode)

Cascade

If nonresident, give place and State

Idaho

If nonresident, give place and State

Idaho

Color or race

White

Age at last Birthday

57
(Years)

Color or race

White

Age at last Birthday

39
(Years)

Birthplace

Shrinking, Mo.
(City and State or Country)

Birthplace

Sherman, Texas
(City and State or Country)

Occupation

Lumberjack

Occupation

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was

Born alive
Stillborn

at 12 30 a M.

on the date above stated.

(Signature)

Rose B. Ford
M.D.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address

Cascade, Idaho

Filed

Feb 11

19 30

Stillborn

Registrar

STATE OF NEW YORK
 COUNTY OF ALBANY
 In SENATE
 January 21, 1914
 REPORT
 OF THE
 COMMISSIONERS OF THE
 DEPARTMENT OF HEALTH
 CONCERNING THE
 DEATH OF
 JOHN J. BROWN
 IN THE
 CITY OF ALBANY
 JANUARY 21, 1914

8131

Where there was no attending physician
 or midwife then the nearest neighbor
 etc. should make this return. A stillborn
 child is one that neither breathed nor
 shows other evidence of life after birth.

On the date above stated

I hereby certify that I attended the birth of this child, who was

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

Place of birth of child
 Name of child
 Sex of child
 Date of birth
 Time of day
 Name of mother
 Name of father
 Name of attending physician or midwife
 Address of attending physician or midwife
 Signature of attending physician or midwife

Place of birth of child
 Name of child
 Sex of child
 Date of birth
 Time of day
 Name of mother
 Name of father
 Name of attending physician or midwife
 Address of attending physician or midwife
 Signature of attending physician or midwife

Place of birth of child
 Name of child
 Sex of child
 Date of birth
 Time of day
 Name of mother
 Name of father
 Name of attending physician or midwife
 Address of attending physician or midwife
 Signature of attending physician or midwife

Place of birth of child
 Name of child
 Sex of child
 Date of birth
 Time of day
 Name of mother
 Name of father
 Name of attending physician or midwife
 Address of attending physician or midwife
 Signature of attending physician or midwife

REC'D MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 69701

PLACE OF DEATH

County of Valley
City of CascadeRegistration District No. 15

Primary Registration District No. _____

Local Registrar's No. _____

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____6. DATE OF BIRTH (month, day and year) Feb 11 - 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Cascade, Ida
(State or country)10. NAME OF FATHER Rufus Hughes11. BIRTHPLACE OF FATHER, (city or town) Missouri
(State or Country)12. MAIDEN NAME OF MOTHER Fada Allen13. BIRTHPLACE OF MOTHER (city or town) Texas
(State or Country)14. Informant Rufus Hughes
(Address) Cascade, Ida15. Filed Feb 11, 1930 Stella Cameron
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw her alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn - Hydrocephalus
and spinal fluid

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted _____
if not at place of death?Did an operation precede death? No Date of _____Was there an autopsy? NoWhat test confirmed diagnosis? None(Signed) Lance E. Ward, M.D.2/11/30, 19____ (Address) Cascade, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal _____ Date of Burial _____

19

20. Undertaker _____ Address _____

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

395 212-001-412
PLACE OF BIRTH

County of Ada
City of Boise
No. St Lukes St.

APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

15

CERTIFICATE OF BIRTH

179285

Registration District No. 2 State File No. 179285

Prim. Registration District No. 1004 Local Registrar's No. 140

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>7</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>7</u>	Legitimate? <u>yes</u>	Date of birth <u>Feb 12 1930</u> (Month) (Day) (Year)
-----------------------	-----------------------------------	-----------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth One (a) Born alive, and now living 0

Born alive but now dead 0 Stillborn One

FATHER FULL NAME <u>R. C. McCreedy</u>	MOTHER FULL MAIDEN NAME <u>Mary Elizabeth Winkler</u>
---	--

Residence (Usual place of abode) Boise

If nonresident, give place and State R 5

Color or race White Age at last Birthday 21 (Years)

Birthplace Pittsburg, Penn. (City and State or Country)

Occupation Surveyor

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 4591
on the date above stated. Stillborn

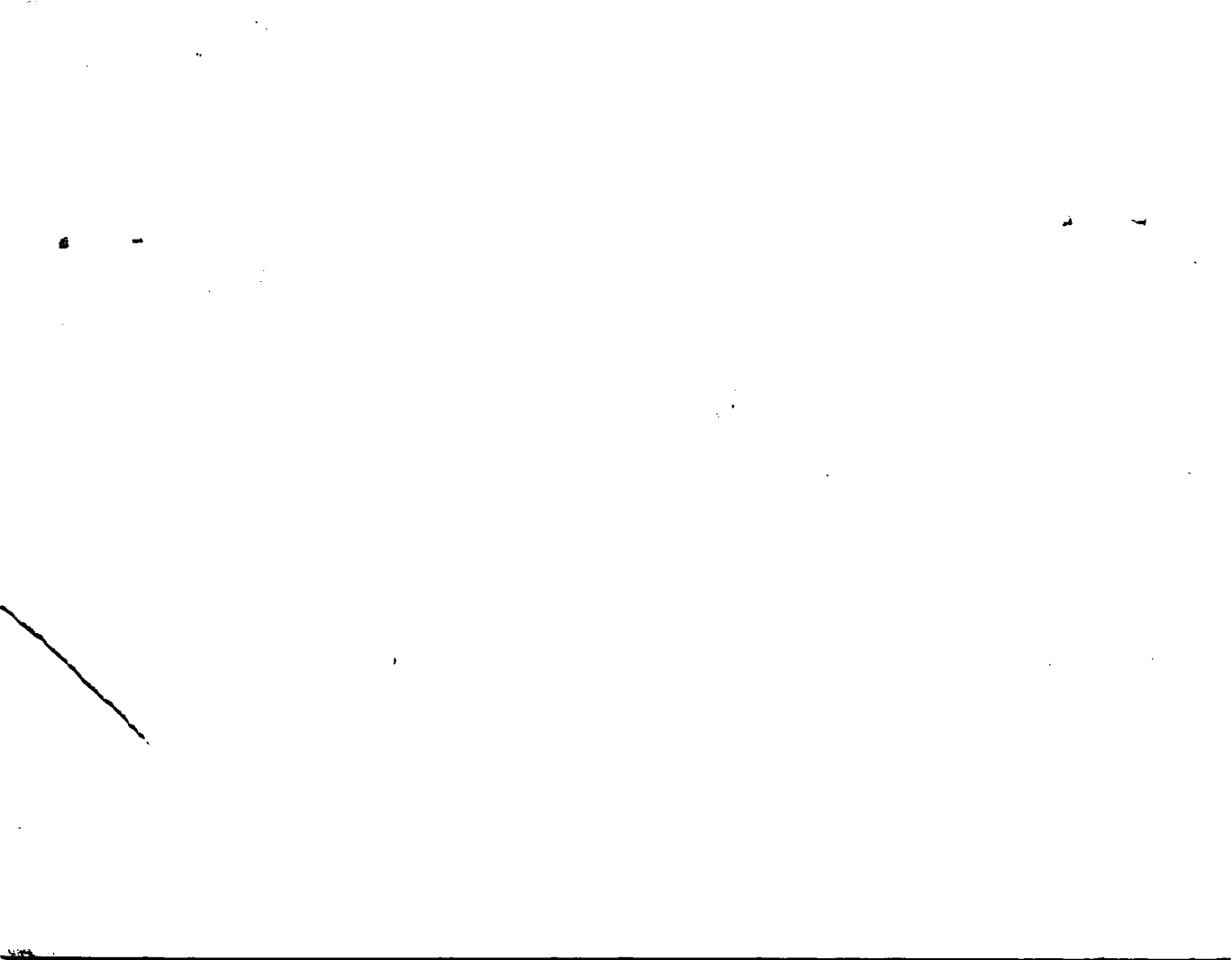
(Signature) A. B. Borch
M. H.
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Boise Idaho

Filed 3-17-1930 W. V. Rhodes

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 11 1930

PLACE OF DEATH

County of AdaCity of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 2Primary Registration District No. 1904(No. St. Luke's Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 62408Local Registrar's No. 502. FULL NAME Infant McCready(a) Residence, No. 2310 Broadway St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Feb-12-19307. AGE Years Months Days If LESS than 1 day,
0 hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise Idaho
(State or country)10. NAME OF FATHER Robert Cob McCready11. BIRTHPLACE OF FATHER (city or town) Oakdale Penn
(State or Country)12. MAIDEN NAME OF MOTHER Mary Elizabeth Winkelman13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)14. Informant Robert C. McCready(Address) Rd # 5, Boise Idaho15. Filed 2-18 1930 U.N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb-12 30 31
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 12 1930, to 19that I last saw him alive on 19and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Still born - Premature
Caesarean
(duration) yrs. mos. ds.CONTRIBUTORY Caesarean
(Secondary)Pregnancy (duration) yrs. mos. ds.18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) B. B. Borch M. D.Feb 15 1930 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Morris Hill Cemetery Feb-17 1930

20. Undertaker Address

Summers & Krebs Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACED RECEIVED APR 15 1930

STATE OF IDAHO

County of Dear Lake

= DEPARTMENT OF PUBLIC WELFARE

City of Paris

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. St.

219 203004-236

Registration District No. 23

State File No.

S

179329

(If born in hospital or institution
give name.)

Prim. Registration District No.

Local Registrar's No.

FULL NAME OF CHILD

Alice Barfuss

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of

Female

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

Date of
birth

Feb. 3

1930

(To be answered only in event of plural births)

(Month)

(Day)

(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

None

Number of child of this mother, including present birth

12

(a)

Born alive and now living

9

Born alive but now dead

2

Stillborn

1

FULL
NAME

Andrew Barfuss

FATHER

FULL
MAIDEN
NAME

Louise Stocker

MOTHER

Residence (Usual place of abode)

Paris Idaho

Residence (Usual place of abode)

Paris Idaho

If nonresident, give place and State

If nonresident, give place and State

Color or race

White

Age at last Birthday

52

(Years)

Color or race

White

Age at last Birthday

41

(Years)

Birthplace

Switzerland

(City and State or Country)

Birthplace

Switzerland

(City and State or Country)

Occupation

Farmer

Occupation

No one wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at
on the date above stated.

(Signature)

Sherris H. Rich

Physician

(Physician or midwife)

Address

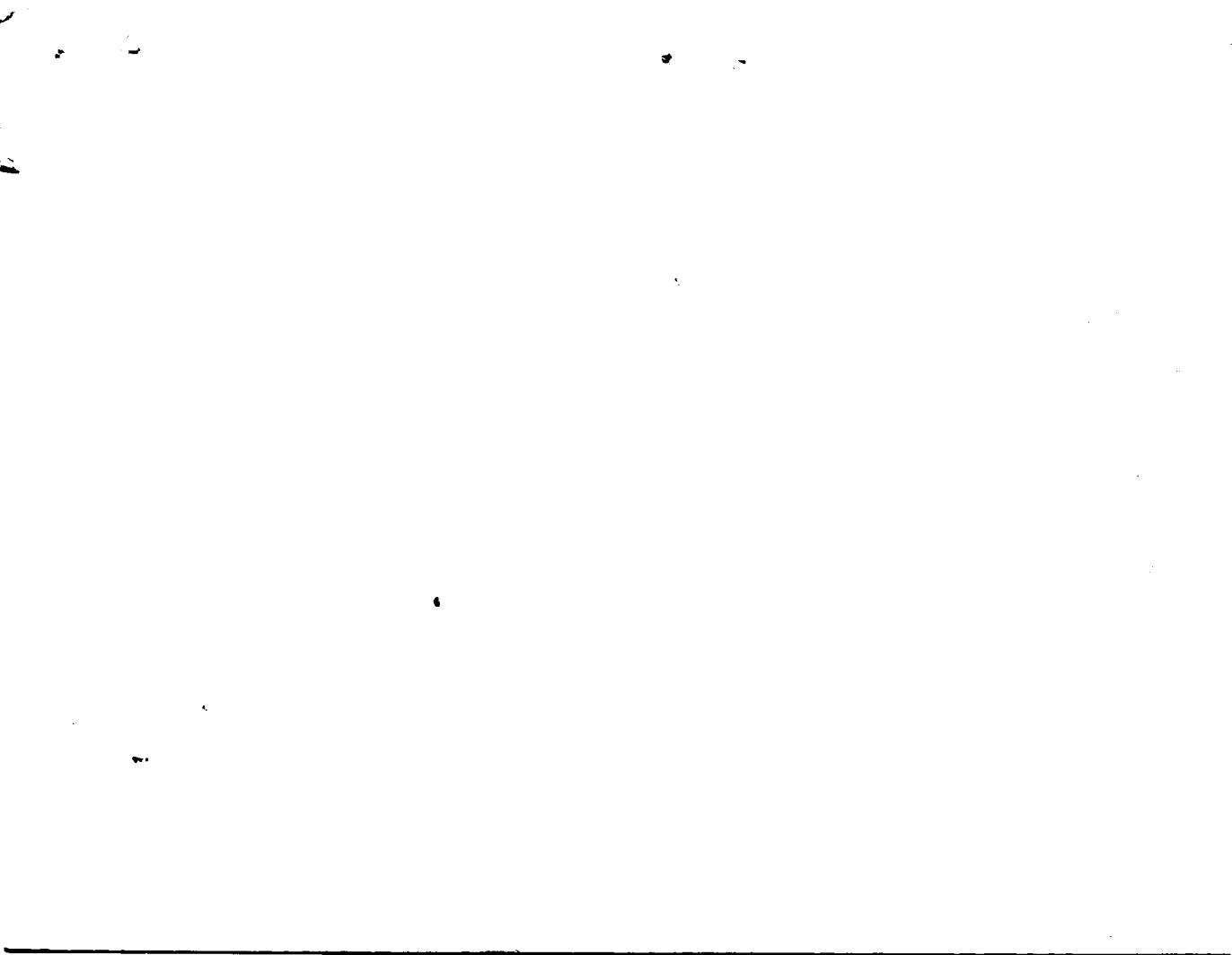
Paris Idaho

Filed 4-18-1930

Mrs. J. D. Skinner

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



RECEIVED FEB 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 69061

PLACE OF DEATH

County of Bear Lake
City of Paris

CERTIFICATE OF DEATH

Registration District No. 6-3

Primary Registration District No.

Local Registrar's No. 142

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alice Barfuss

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX

Female

4. COLOR OR RACE

white

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Feb. 3 19307. AGE Years Months Days 11 yrs. 11 mos. 11 ds. 11 hrs. 11 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Paris Idaho
(State or country)10. NAME OF FATHER Andrew Barfuss11. BIRTHPLACE OF FATHER (city or town) Switzerland
(State or Country)12. MAIDEN NAME OF MOTHER Louise Stoecker13. BIRTHPLACE OF MOTHER (city or town) Germany
(State or Country)14. Informant Andrew Barfuss
(Address)15. Filed Feb 5, 1930 Mrs. J. S. Kummer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 3, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 3, 1930, to Feb. 3, 1930
that I last saw her alive on Feb. 3, 1930and that death occurred, on the date stated above, at unknownThe CAUSE OF DEATH* was as follows:
Rupture of Umbilical Cord

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Manual Electric(Signed) Palmer Spencer H. Price, M. D.Feb. 3, 1930 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Paris Idaho Date of Burial Feb. 3, 193020. Undertaker Edwin T. Shepherd Address Paris Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia, ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH 849-127 003-168

STATE OF IDAHO

W. B. Brothers

County of Blaine APR 11 1930
City of ocatille

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 179347

No. Poe. Sen. Hosp. St.

Registration District No. 28 State File No. 9229

(If born in hospital or institution
give name.)

Prim. Registration District No. 216 Local Registrar's No. 9229

FULL NAME OF CHILD "Stillbirth" Hurst
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twins or other? <u>Triplet</u>	and	Number in order of birth <u>—</u>	Legitimate? <u>Yes</u>	Date of birth <u>Mar. 27</u> 192 <u>9</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 3 (a) Born alive and now living 1

Born alive but now dead 0 Stillborn 2

FATHER FULL NAME <u>Clarence Merlyn Hurst</u>	MOTHER FULL MAIDEN NAME <u>Eva Marie Johnson</u>
--	---

Residence (Usual place of abode) Blackfoot

It non-resident, give place and State —

Color or race white Age at last Birthday 43(?) (Years)

Birthplace Kansas (City and State or County)

Occupation Bee Keeper

It non-resident, give place and State —

Color or race white Age at last Birthday 28 (Years)

Birthplace Nebraska (City and State or County)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn — at 11:45 P. M. on the date above stated.

(Signature) W. B. Brothers

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address Priddy, Ida

Filed 11. 1930 J. H. H. H.

Registrar

[illegible][illegible]

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific information required.

(9415842)

9/15/54

STATE OF ALABAMA

NOTES

100-31032-10A-117

2015/03/15

trial of these

CONFIDENTIAL

...to make sure...

共31页

2. Left

WESTERN OILFIELD

7-2000-11-11

1997

1998

APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69778

PLACE OF DEATH

County of BannockCity of PocatelloRegistration District No. 28Primary Registration District No. 2161(No. Gen Hospital Pocatello Idaho)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 57922. FULL NAME Infant Hurst(a) Residence. No. Blackfoot Idaho St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. Single, Married, Widowed, or Divorced (write the word)

Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

March 28-1930

7. AGE

Years

Months

Days

LESS than 1 day,
Full hour or
min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none9. BIRTHPLACE (city or town)
(State or country)Pocatello Idaho

10. NAME OF FATHER

C. M. Hurst11. BIRTHPLACE OF FATHER (city or town)
(State or Country)Kansas

12. MAIDEN NAME OF MOTHER

Eva Johnson13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)Wyomark

14. Informant

(Address) Blackfoot Idaho

15. Filed

3/24 1930J. J. Young

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3-28 1930, to 3-28 1930that I last saw her alive on Sept 1 19 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Still born

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Eclampsia of mother
(duration) yrs. mos. ds. 218. Where was disease contracted
if not at place of death?Did an operation precede death? Yes Date of Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W. W. Brothers M. D.3-28 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Blackfoot Idaho March 28 1930

20. Undertaker

Address

H. S. McFarland Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACED IN RECEPTION APR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 179420

County of Bonner
City of Patuxai
No. St.

231 222-009 419
(If born in hospital or institution
give name.)

Registration District No. 26 State File No. 179420

Prim. Registration District No. 2155 Local Registrar's No. 41

FULL NAME OF CHILD

Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mated?	Date of birth <u>Mar. 22</u> 19 <u>30</u> (Month) (Day) (Year)
----------------------------	---	-----	--------------------------------	-------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? Yes

Number of child of this mother, including present birth 5 (a) Born alive and now living 4

Born alive but now dead 1 Stillborn 1

FATHER FULL NAME <u>Luther Earl Starr</u>	MOTHER FULL MAIDEN NAME <u>Myrtle Warrell</u>
--	--

Residence (Usual place of abode) <u>Patuxai, Ida</u>	Residence (Usual place of abode) <u>Patuxai, Ida</u>
--	--

If nonresident, give place and State

Color or race <u>White</u> Age at last Birthday <u>35</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>35</u> (Years)
---	---

Birthplace <u>Iowa</u> (City and State or Country)	Birthplace <u>Chicago, Ill</u> (City and State or Country)
---	---

Occupation <u>Housewife</u>	Occupation <u>Housewife</u>
-----------------------------	-----------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

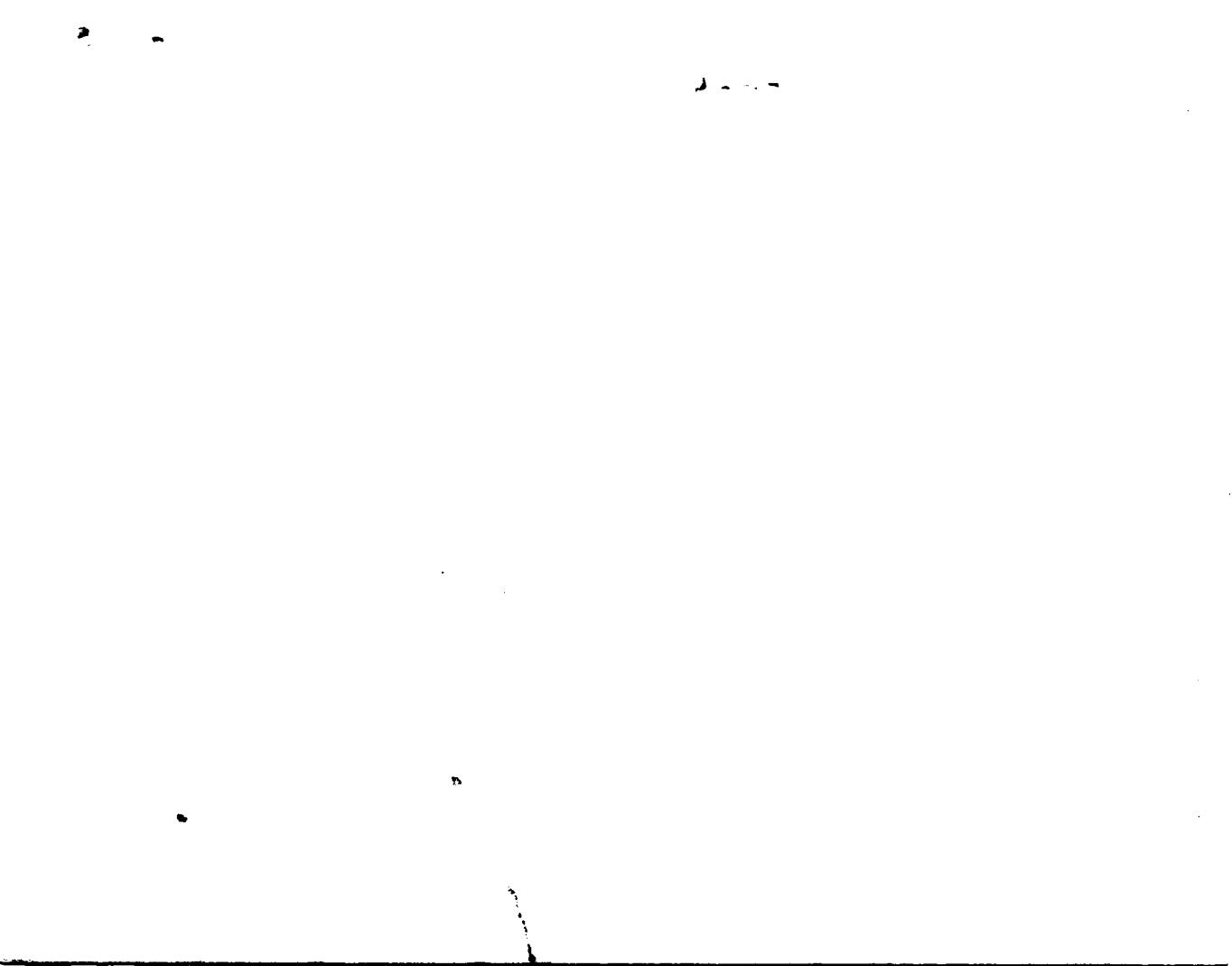
I hereby certify that I attended the birth of this child, who was Stillborn at 8:40 P. M. on the date above stated.

(Signature) [Signature]

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Idaho

Filed April 3 1930
Viola Allen
Deputy Registrar



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69821

PLACE OF DEATH

County of Bonner
City of Kootenai

Registration District No. 78
Primary Registration District No. 2155

Local Registrar's No. 30

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Starr

(a) Residence. No. Kootenai Ida St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 22, 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
still birth

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Kootenai
(State or country) Idaho

10. NAME OF FATHER Luther E Starr

11. BIRTHPLACE OF FATHER (city or town) Iowa
(State or Country)

12. MAIDEN NAME OF MOTHER Myrtle Darrell

13. BIRTHPLACE OF MOTHER (city or town) Illinois
(State or Country)

14. Informant L. E. Starr
(Address) Kootenai Ida

15. Filed March 24, 1930
Judy Allen
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 22, 1930, to Mar 27, 1930, that I last saw him alive on Mar 27, 1930, and that death occurred, on the date stated above, at 9 P. m. The CAUSE OF DEATH* was as follows:

Still born Cause unknown
Gestation: 9 mos.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? _____
Did an operation precede death? _____ Date of _____
Was there an autopsy? _____

What test confirmed diagnosis? _____
(Signed) R. J. Ross M. D.
Mar. 24, 1930 (Address) fundpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lakerview Cemetery Date of Burial Mar 24 1930

20. Undertaker Trenbull Co Address Seandpoint

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

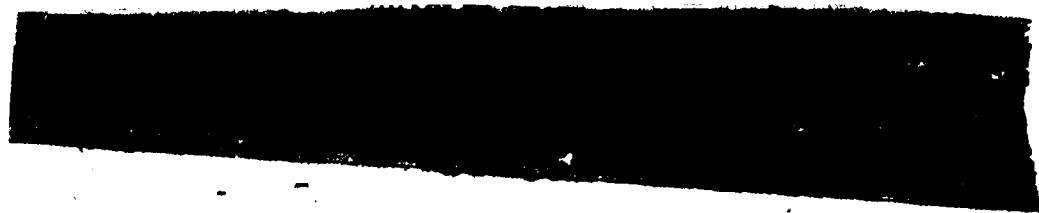
statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO		DEPARTMENT OF PUBLIC WELFARE		BUREAU OF VITAL RECORDS	
County of Canyon		City of Caldwell		No. 445 102014		Caldwell Sanitarium	
(If born in hospital give name.)		Prim. Registration District No. 2007		Local Registrar's No. 69		179495	
FULL NAME OF CHILD		Stillborn		(If stillborn, substitute the word "Stillbirth" for name of child)			
Sex of Child	Boy	Twin Triplet or other?	and	Number in order of birth	Legitimate? Yes	Date of birth	4/2/30
		(To be answered only in event of plural births)				(Month)	(Day)
						(Year)	19
What prophylactic was used to prevent Ophthalmia Neonatorum?							
Number of child of this mother, including present birth				(a) Born alive and now living			
Born alive but now dead				Stillborn			
FATHER				MOTHER			
FULL NAME R. M. Dunagan				FULL MAIDEN NAME Love Stermer			
Residence (Usual place of abode) Parma, Idaho				Residence (Usual place of abode) Parma, Idaho			
If nonresident, give place and State				If nonresident, give place and State			
Color or race White		Age at last Birthday 21		Color or race White		Age at last Birthday 20	
		(Years)				(Years)	
Birthplace Idaho		(City and State or Country)		Birthplace Idaho		(City and State or Country)	
Occupation Farming				Occupation Housewife			
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*							
I hereby certify that I attended the birth of this child, who was { Born alive } at 7:30 A. M.							
on the date above stated. { Stillborn }							
(Signature)				F. L. Cole			
				P. D.			
				(Physician or midwife)			
Address Caldwell, Idaho				Filed 4-4-1930			
				John S. Meyer			
				Registrar.			

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69850

County of Canyon
City of Edgewood

Registration District No. 9
Primary Registration District No. 2005

Local Registrar's No. 34

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bobby Thurman

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 4/2 30

7 AGE Years Months Days 1 day 2 hrs. or 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Edgewood Idaho
(State or country)

10 NAME OF FATHER R. H. Thurman

11 BIRTHPLACE OF FATHER (city or town) Edgewood
(State or country)

12 MAIDEN NAME OF MOTHER Lora Simpson

13 BIRTHPLACE OF MOTHER (city or town) Edgewood
(State or country)

14 Informant R. H. Thurman
(Address) Parma, Idaho, Box 1

15 Filed 4-2-1930 John H. Meyers
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 2 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 2 1930 to April 2 1930, that I last saw him alive on April 2 1930, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

Breath injury Very
different instrument
allowing
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) R. H. Thurman, M. D.
4/2 1930 (Address) Edgewood

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Roswell Cem. Date of Burial 4-3-1930

20. Undertaker Father and Friends Address Parma - Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a mid wife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PERMANENT BIRTH APR 4 1930

County of Elmore
City of Glenn's Ferry
No. 162 118 204114 St.

(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S
179532

Registration District No. 35 State File No. 2021

Prim. Registration District No. 2021 Local Registrar's No. 179532

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twins or other? <u>None</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>March 8 - 1930</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 4 (a) Born alive and now living 2

Born alive but now dead None Stillborn 2

FATHER FULL NAME <u>Volmer F. Johnson</u>	MOTHER FULL MAIDEN NAME <u>Ethel Annie Madsen</u>
--	--

Residence (Usual place of abode) Glenn's Ferry Idaho Residence (Usual place of abode) Glenn's Ferry

If nonresident, give place and State _____ If nonresident, give place and State _____

Color or race white Age at last Birthday 39 Color or race white Age at last Birthday _____
(Years) (Years)

Birthplace Utah Birthplace Utah
(City and State or Country) (City and State or Country)

Occupation Boiler maker O.L.R.R. Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at Glenn's Ferry M.
on the date above stated.

(Signature) Dr. J. W. Davis

(Physician or midwife)

Address Glenn's Ferry Idaho

Filed 3-17-1930 Mrs. Mary Sullivan
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

2

1

2

1

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 4 1930

- PLACE OF DEATH

County of ElmoreCity of Glenns Ferry

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 33Primary Registration District No. 2021

DO NOT WRITE IN THIS SPACE

State File No. 69894Local Registrar's No. not(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Stillborn

(a) Residence. No. _____ St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) Single5a. If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____6. DATE OF BIRTH (month, day and year) March 8 - 19307. AGE Years Months Days If LESS than 1 day,
0 0 0 _____ hrs. or
min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work _____(b) General nature of industry,
business, or establishment in
which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Glenns Ferry Ida
(State or country)10. NAME OF FATHER Volmer F. Johnson11. BIRTHPLACE OF FATHER (city or town) Utah
(State or Country)12. MAIDEN NAME OF MOTHER Ethel Annie Madsen13. BIRTHPLACE OF MOTHER (city or town) Utah
(State or Country)14. Informant Mrs. Volmer Johnson
(Address) Glenns Ferry Ida15. Filed 3-17 1930 Mrs. Mary Sullivan
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 8 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Dr. J. H. Davis M. D.
3-17 1930 (Address) Glenns Ferry Ida*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.19. Place of Burial, Cremation, or Removal Glenns Ferry Ida Date of Burial 3-8 193020. Undertaker Volmer Johnson Address Glenns Ferry Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29 ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Franklin APR 9 1930
City of Mink Creek Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

No. 251-109 021-157 St.

Registration District No. 27 State File No. 179570

(If born in hospital or institution
give name.)

Prim. Registration District No. 2119 Local Registrar's No.

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other?	and	Number in order of birth	Legiti- mate?	Date of birth <u>Mar 9</u>	19 <u>30</u>
(To be answered only in event of plural births)				<u>yes</u>	(Month) (Day) (Year)	

What prophylactic was used to prevent Ophthalmia Neonatorum? to

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead Stillborn

FATHER
FULL NAME Melvin Seamans

MOTHER
FULL MAIDEN NAME Lura Jenson

Residence (Usual place of abode) Mink Creek, Ida

Residence (Usual place of abode) Mink Creek, Ida

If non-resident, give place and State

If non-resident, give place and State

Color or race White Age at last Birthday 26 (Years)

Color or race White Age at last Birthday 27 (Years)

Birthplace Chandler Ida
(City and State or County)

Birthplace Mink Creek, Ida
(City and State or County)

Occupation Farmer

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at Idaho on the date above stated.

(Signature) Eugene Morley

(Physician or midwife)

Address Denton Ida

Filed Mar 11 1930 G. R. Cuthbert

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

UNITED STATES DEPARTMENT OF JUSTICE
BUREAU OF PRISONS
WASHINGTON, D. C.

191

Registration District No. _____
County _____ State _____

STATE OF _____

If applicant submits the following facts of birth:

Full Name	Age	Sex	Color	Height	Weight	Build	Complexion	Birth Date	Birth Place	Parents
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

was there to present original documents?

Number of days of this birth (including present day) _____

Birth date and day _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1930
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69906

County of Franklin
City of Mink Creek Ida

Registration District No. 27
Primary Registration District No. 2119

Local Registrar's No. 206

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 9, 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Mink Creek Ida
(State or country)

10. NAME OF FATHER Melvin Seamons

11. BIRTHPLACE OF FATHER (city or town) Cleveland Ida
(State or Country)

12. MAIDEN NAME OF MOTHER Lora Jappson

13. BIRTHPLACE OF MOTHER (city or town) Mink Creek Ida
(State or Country)

14. Informant Melvin Seamons
(Address) Mink Creek, Ida

15. Filed Mar 11, 1930 G. R. Queller
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 9 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 9, 1930 to Mar 9, 1930
that I last saw him never lived 1930
and that death occurred, on the date stated above, at 13⁰⁰ a. m.

The CAUSE OF DEATH* was as follows:
Premature Birth

CONTRIBUTORY Instrumental delivery
(Secondary) (duration) yrs. mos. ds.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of _____
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Eugen M. D.
Mar 9, 1930 (Address) Preston

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mink Creek, Ida Date of Burial Mar. 10 1930

20. Undertaker Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Salesman, (b) Grocery;** (a) **Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29 ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of Jefferson
City of Idaho
No. _____ St. _____

RECEIVED MAR 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 179674

266-222-026-365
(If born in hospital or institution
give name.)

Registration District No. _____ State File No. _____

Prim. Registration District No. 2/26 Local Registrar's No. 6

FULL NAME OF CHILD Not named. (Stillbirth)

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Feb 22 1930</u> (Month) (Day) (Year)
----------------------------	---	--------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FULL NAME <u>Thomas Lyman Bowles</u> FATHER	FULL MAIDEN NAME <u>Martha Leone Louell</u> MOTHER
--	---

Residence (Usual place of abode) Ririe, Ida.

If nonresident, give place and State _____

Color or race Wht. Age at last Birthday 20
(Years)

Birthplace Nephi, Utah
(City and State or Country)

Occupation Farming

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 7:10 P. M.
on the date above stated.

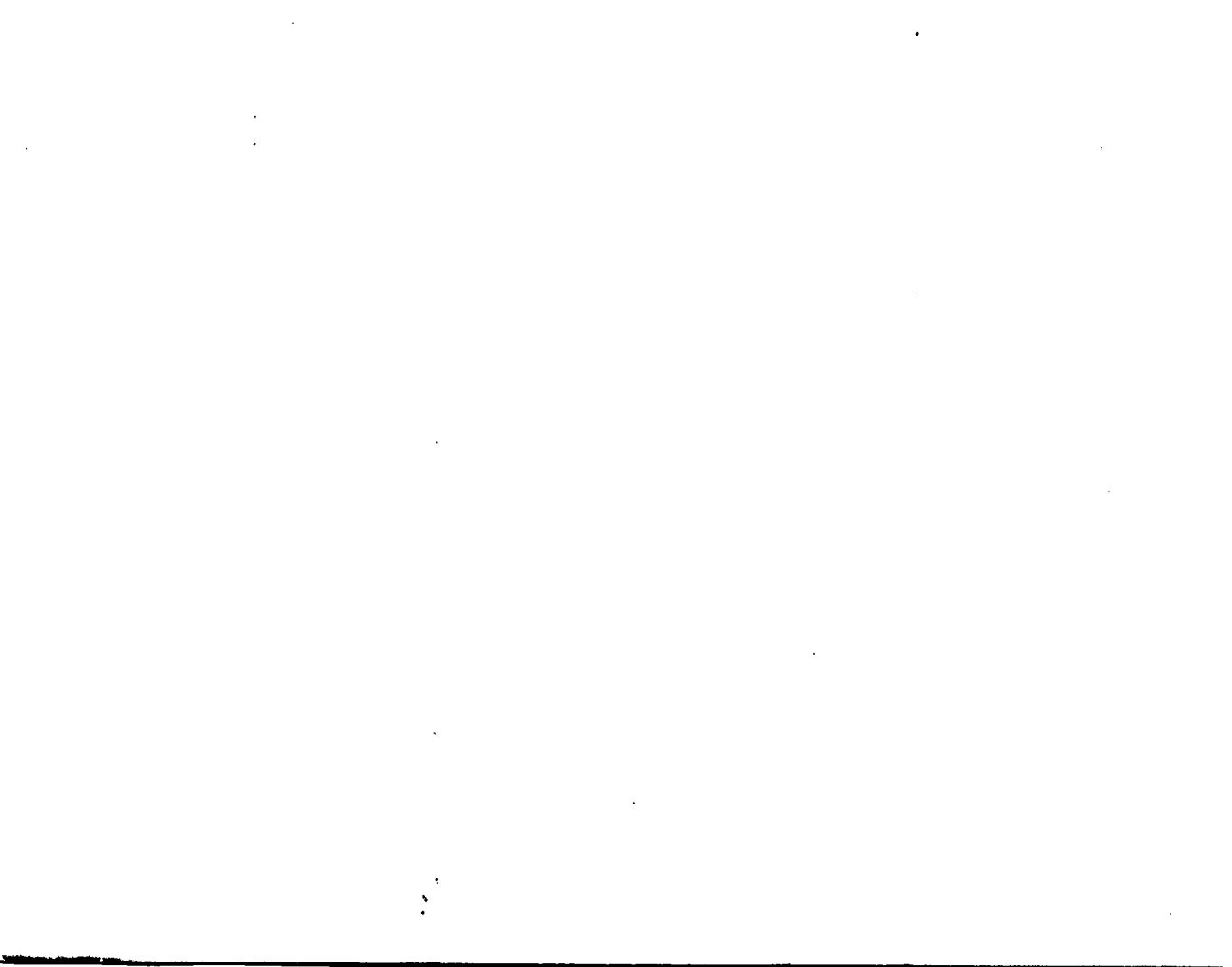
(Signature) H. R. Abbott M.D.

(Physician or midwife)

Address Ririe, Idaho

Filed MAR 1 1930 C. H. GAVIN, M.D.
19 _____ Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

863-212-03-955
PLACED **RECEIVED** APR 11 1930

S

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

179760

County of Danboeck
City of Pocatello
No. St. Anthony St.

Registration District No. 28 State File No. 2161

(If born in hospital or institution
give name.) Hospital

Prim. Registration District No. 2161 Local Registrar's No. 9686

FULL NAME OF CHILD (Still born) Donna Lee Halcomb
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> }</u> and <u> }</u> Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>2-12</u> 19 <u>30</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead Stillborn

FATHER
FULL NAME Willis C. Halcomb
Residence (Usual place of abode) 616 North 18th
If non-resident, give place and State
Color or race W Age at last Birthday 21 (Years)
Birthplace St. Anthony, Idaho (City and State or County)
Occupation Gandy maker

MOTHER
FULL MAIDEN NAME Leah Margaret Reese
Residence (Usual place of abode) 816 North 18th
If non-resident, give place and State
Color or race W Age at last Birthday 20 (Years)
Birthplace Goldberg, Idaho (City and State or County)
Occupation House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 6 45 M. P
on the date above stated. Stillborn

(Signature) J. Miller
(Physician or midwife)

Address Pocatello, Idaho
Filed 4/11/30 J. H. Hanning
Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

1900, J. I. Evans, a white man, was arrested for the same offense. He was fined \$100 and costs. He was also ordered to pay the costs of the prosecution. He was also ordered to pay the costs of the prosecution. He was also ordered to pay the costs of the prosecution.

1. The County of ...
 2. ...
 3. ...
 4. ...
 5. ...
 6. ...
 7. ...
 8. ...
 9. ...
 10. ...
 11. ...
 12. ...
 13. ...
 14. ...
 15. ...
 16. ...
 17. ...
 18. ...
 19. ...
 20. ...
 21. ...
 22. ...
 23. ...
 24. ...
 25. ...
 26. ...
 27. ...
 28. ...
 29. ...
 30. ...
 31. ...
 32. ...
 33. ...
 34. ...
 35. ...
 36. ...
 37. ...
 38. ...
 39. ...
 40. ...
 41. ...
 42. ...
 43. ...
 44. ...
 45. ...
 46. ...
 47. ...
 48. ...
 49. ...
 50. ...
 51. ...
 52. ...
 53. ...
 54. ...
 55. ...
 56. ...
 57. ...
 58. ...
 59. ...
 60. ...
 61. ...
 62. ...
 63. ...
 64. ...
 65. ...
 66. ...
 67. ...
 68. ...
 69. ...
 70. ...
 71. ...
 72. ...
 73. ...
 74. ...
 75. ...
 76. ...
 77. ...
 78. ...
 79. ...
 80. ...
 81. ...
 82. ...
 83. ...
 84. ...
 85. ...
 86. ...
 87. ...
 88. ...
 89. ...
 90. ...
 91. ...
 92. ...
 93. ...
 94. ...
 95. ...
 96. ...
 97. ...
 98. ...
 99. ...
 100. ...

1. NAME
 2. ADDRESS
 3. CITY
 4. STATE
 5. ZIP
 6. PHONE
 7. TELETYPE
 8. TELEFAX
 9. TELEMAIL
 10. TELEFAX
 11. TELEMAIL
 12. TELEFAX
 13. TELEMAIL
 14. TELEFAX
 15. TELEMAIL
 16. TELEFAX
 17. TELEMAIL
 18. TELEFAX
 19. TELEMAIL
 20. TELEFAX
 21. TELEMAIL
 22. TELEFAX
 23. TELEMAIL
 24. TELEFAX
 25. TELEMAIL
 26. TELEFAX
 27. TELEMAIL
 28. TELEFAX
 29. TELEMAIL
 30. TELEFAX
 31. TELEMAIL
 32. TELEFAX
 33. TELEMAIL
 34. TELEFAX
 35. TELEMAIL
 36. TELEFAX
 37. TELEMAIL
 38. TELEFAX
 39. TELEMAIL
 40. TELEFAX
 41. TELEMAIL
 42. TELEFAX
 43. TELEMAIL
 44. TELEFAX
 45. TELEMAIL
 46. TELEFAX
 47. TELEMAIL
 48. TELEFAX
 49. TELEMAIL
 50. TELEFAX
 51. TELEMAIL
 52. TELEFAX
 53. TELEMAIL
 54. TELEFAX
 55. TELEMAIL
 56. TELEFAX
 57. TELEMAIL
 58. TELEFAX
 59. TELEMAIL
 60. TELEFAX
 61. TELEMAIL
 62. TELEFAX
 63. TELEMAIL
 64. TELEFAX
 65. TELEMAIL
 66. TELEFAX
 67. TELEMAIL
 68. TELEFAX
 69. TELEMAIL
 70. TELEFAX
 71. TELEMAIL
 72. TELEFAX
 73. TELEMAIL
 74. TELEFAX
 75. TELEMAIL
 76. TELEFAX
 77. TELEMAIL
 78. TELEFAX
 79. TELEMAIL
 80. TELEFAX
 81. TELEMAIL
 82. TELEFAX
 83. TELEMAIL
 84. TELEFAX
 85. TELEMAIL
 86. TELEFAX
 87. TELEMAIL
 88. TELEFAX
 89. TELEMAIL
 90. TELEFAX
 91. TELEMAIL
 92. TELEFAX
 93. TELEMAIL
 94. TELEFAX
 95. TELEMAIL
 96. TELEFAX
 97. TELEMAIL
 98. TELEFAX
 99. TELEMAIL
 100. TELEFAX

[illegible]

1. General
 2. Specific
 3. Particular
 4. Detail
 5. Example
 6. Illustration
 7. Case
 8. Instance
 9. Sample
 10. Model
 11. Pattern
 12. Form
 13. Shape
 14. Figure
 15. Diagram
 16. Sketch
 17. Outline
 18. Plan
 19. Design
 20. Blueprint
 21. Map
 22. Chart
 23. Graph
 24. Table
 25. Form
 26. Sheet
 27. Page
 28. Volume
 29. Issue
 30. Number
 31. Page
 32. Volume
 33. Issue
 34. Number
 35. Page
 36. Volume
 37. Issue
 38. Number
 39. Page
 40. Volume
 41. Issue
 42. Number
 43. Page
 44. Volume
 45. Issue
 46. Number
 47. Page
 48. Volume
 49. Issue
 50. Number
 51. Page
 52. Volume
 53. Issue
 54. Number
 55. Page
 56. Volume
 57. Issue
 58. Number
 59. Page
 60. Volume
 61. Issue
 62. Number
 63. Page
 64. Volume
 65. Issue
 66. Number
 67. Page
 68. Volume
 69. Issue
 70. Number
 71. Page
 72. Volume
 73. Issue
 74. Number
 75. Page
 76. Volume
 77. Issue
 78. Number
 79. Page
 80. Volume
 81. Issue
 82. Number
 83. Page
 84. Volume
 85. Issue
 86. Number
 87. Page
 88. Volume
 89. Issue
 90. Number
 91. Page
 92. Volume
 93. Issue
 94. Number
 95. Page
 96. Volume
 97. Issue
 98. Number
 99. Page
 100. Volume
 101. Issue
 102. Number
 103. Page
 104. Volume
 105. Issue
 106. Number
 107. Page
 108. Volume
 109. Issue
 110. Number
 111. Page
 112. Volume
 113. Issue
 114. Number
 115. Page
 116. Volume
 117. Issue
 118. Number
 119. Page
 120. Volume
 121. Issue
 122. Number
 123. Page
 124. Volume
 125. Issue
 126. Number
 127. Page
 128. Volume
 129. Issue
 130. Number
 131. Page
 132. Volume
 133. Issue
 134. Number
 135. Page
 136. Volume
 137. Issue
 138. Number
 139. Page
 140. Volume
 141. Issue
 142. Number
 143. Page
 144. Volume
 145. Issue
 146. Number
 147. Page
 148. Volume
 149. Issue
 150. Number
 151. Page
 152. Volume
 153. Issue
 154. Number
 155. Page
 156. Volume
 157. Issue
 158. Number
 159. Page
 160. Volume
 161. Issue
 162. Number
 163. Page
 164. Volume
 165. Issue
 166. Number
 167. Page
 168. Volume
 169. Issue
 170. Number
 171. Page
 172. Volume
 173. Issue
 174. Number
 175. Page
 176. Volume
 177. Issue
 178. Number
 179. Page
 180. Volume
 181. Issue
 182. Number
 183. Page
 184. Volume
 185. Issue
 186. Number
 187. Page
 188. Volume
 189. Issue
 190. Number
 191. Page
 192. Volume
 193. Issue
 194. Number
 195. Page
 196. Volume
 197. Issue
 198. Number
 199. Page
 200. Volume
 201. Issue
 202. Number
 203. Page
 204. Volume
 205. Issue
 206. Number
 207. Page
 208. Volume
 209. Issue
 210. Number
 211. Page
 212. Volume
 213. Issue
 214. Number
 215. Page
 216. Volume
 217. Issue
 218. Number
 219. Page
 220. Volume
 221. Issue
 222. Number
 223. Page
 224. Volume
 225. Issue
 226. Number
 227. Page
 228. Volume
 229. Issue
 230. Number
 231. Page
 232. Volume
 233. Issue
 234. Number
 235. Page
 236. Volume
 237. Issue
 238. Number
 239. Page
 240. Volume
 241. Issue
 242. Number
 243. Page
 244. Volume
 245. Issue
 246. Number
 247. Page
 248. Volume
 249. Issue
 250. Number
 251. Page
 252. Volume
 253. Issue
 254. Number
 255. Page
 256. Volume
 257. Issue
 258. Number
 259. Page
 260. Volume
 261. Issue
 262. Number
 263. <

INVESTIGATION REPORT

RECEIVED

1970 JAN 10

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D.C.

1-10-70

W. L. ... to ...
... to ...
... to ...
... to ...
... to ...

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69437

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2141

Local Registrar's No. 5762

(No. St Anthony Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Holcomb

(a) Residence. No. 816 North 12th St. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. Single, Married, Widowed, or Divorced (write the word)

Single

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 12, 1930.

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillborne

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello
(State or country) Idaho

10. NAME OF FATHER

W. C. Holcomb

11. BIRTHPLACE OF FATHER (city or town) St Anthony
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Leah Reese

13. BIRTHPLACE OF MOTHER (city or town) Goldburg
(State or Country) Idaho

14. Informant W. C. Holcomb
(Address) 816 No 12th Ave

15. Filed 2/13, 1930
[Signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 12th. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still birth
Breach delivery

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY
(Secondary)

Strangled Cord
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [Signature], M. D.

2/13, 1930 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Mountain View Cemetery Feb 13 1930

20. Undertaker Address

Hall Mortuary Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED APR 4 1930

PLACE OF BIRTH

County of Minidoka

City of Rupert

No. 863-122034693

James Maternity Home
(If born in hospital or institution give name.)

Registration District No. 19

State File No.

Prim. Registration District No. 2015

Local Registrar's No. 50

CERTIFICATE OF BIRTH

179841

FULL NAME OF CHILD

Still born

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>boy</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>yes</u>	Date of birth <u>Mar 22</u> (Month) (Day) (Year) <u>1930</u>
-------------------------	---	-----	---	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FULL NAME Victor FATHER Paul

FULL MAIDEN NAME Ellen C. Whiffen MOTHER Whiffen

Residence (Usual place of abode) Rupert

Residence (Usual place of abode) Rupert

If nonresident, give place and State Idaho

If nonresident, give place and State Idaho

Color or race White Age at last Birthday 39
(Years)

Color or race White Age at last Birthday 38
(Years)

Birthplace Mont
(City and State or Country)

Birthplace Ontario
(City and State or Country)

Occupation Farmer

Occupation House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

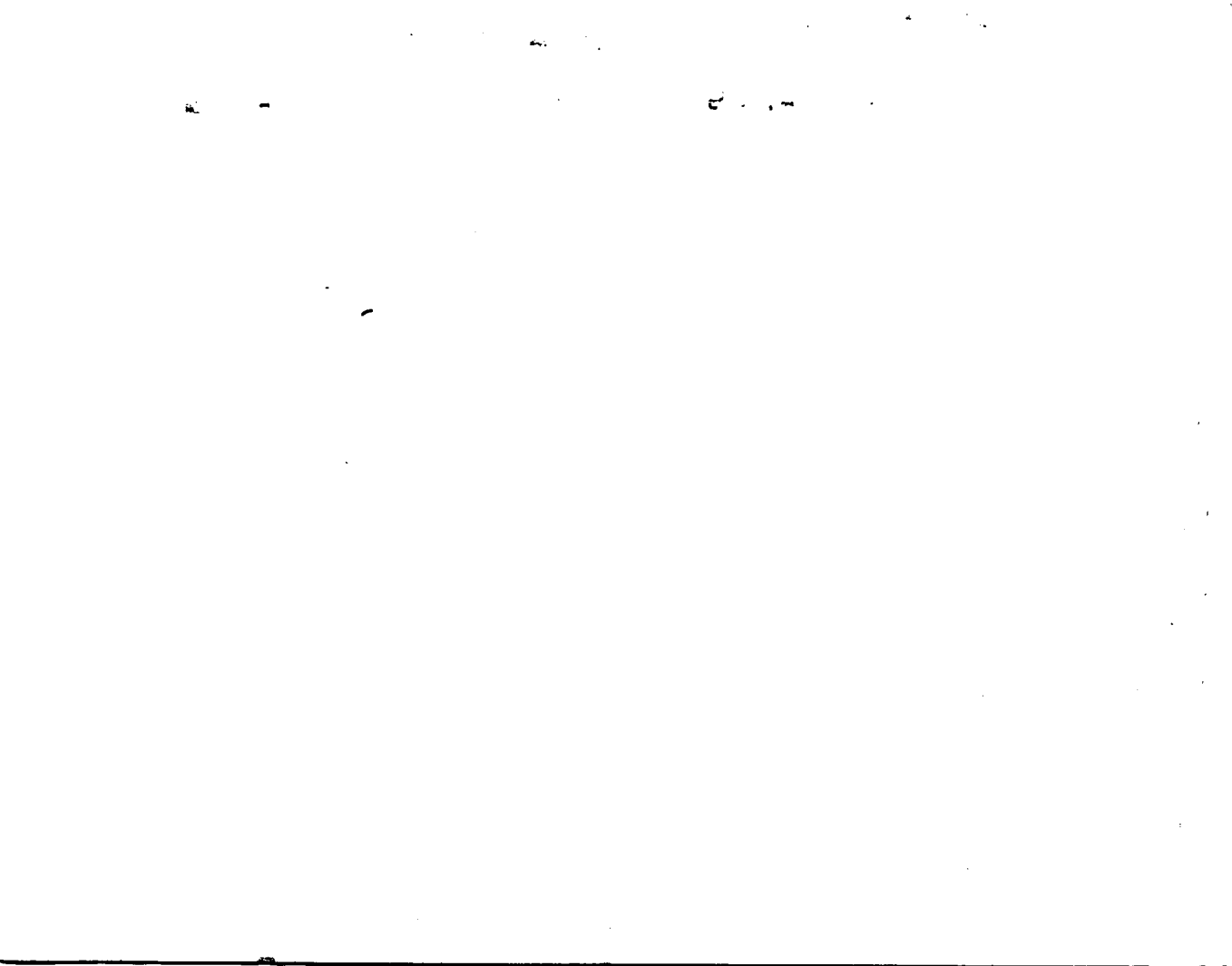
I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 4 P. M. on the date above stated.

(Signature) Imre H. Kenagy
(Physician or midwife)

Address Rupert

Filed 3-31 1930 Ellen C. Whiffen
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 20012

PLACE OF DEATH

County of ShoshoneCity of RupertRegistration District No. 19Primary Registration District No. 2012Local Registrar's No. 17

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Still Born 1stale

(a) Residence. No. _____ St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced Child (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min. Still

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Idaho
(State or country)10. NAME OF FATHER Victor R. Hall11. BIRTHPLACE OF FATHER (city or town) Montana
(State or Country)12. MAIDEN NAME OF MOTHER Ellen Williams13. BIRTHPLACE OF MOTHER (city or town) Canada
(State or Country)

14. Informant Victor R. Hall
(Address) Rupert Idaho R. 3.

15. Filed 6-10, 1930 Ed E. Moore
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____,
that I last saw him alive on _____, 19____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
asphyxia neonatorum

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Jay H. Kenagy, M. D.5-13 1930 (Address) Rupert

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rupert Cemetery Date of Burial Mar 23 1930

20. Undertaker W. A. Goodenough Address Rupert Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

219-122-035-619
PLACE OF BIRTH
RECEIVED MAR 31 1930STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of My placeCity of Lewiston

No. _____ St. _____

Registration District No. 96File No. 179844Hospital WhitesPrimary Registration District No. 1009

Registered No. _____

FULL NAME OF CHILD

Paul Edward Kartemian

(Certificate of no value without full name of child.)

Sex of
ChildmaleTwin
Triplet
or other?

{ and }

{ Number
in order
of birth }1Legiti-
mate?yesDate of
birthFeb 221930

(Month) (Day) (Year)

What bactericidal solution was used in eyes? 20 70 argyrolNumber of child of this mother, including present birth..... 1Number of children of this mother now living, including present birth..... 1FULL
NAME

FATHER

Henry Albert Kartemian

RESIDENCE

Kendrick Ida

COLOR

whiteAGE AT LAST
BIRTHDAY35

(Years)

BIRTHPLACE

Sawa

OCCUPATION

LaborFULL
MAIDEN
NAME

MOTHER

Grace Swanson Waitt

RESIDENCE

Kendrick, Ida

COLOR

whiteAGE AT LAST
BIRTHDAY39

(Years)

BIRTHPLACE

Washington

OCCUPATION

House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was..... at..... M.
on the date above stated. 12 30 17

(Born alive or stillborn)

(Signature)

E. L. White

(Physician or midwife)

Address

Lew. Ida

Filed

Jan 11930E. L. White

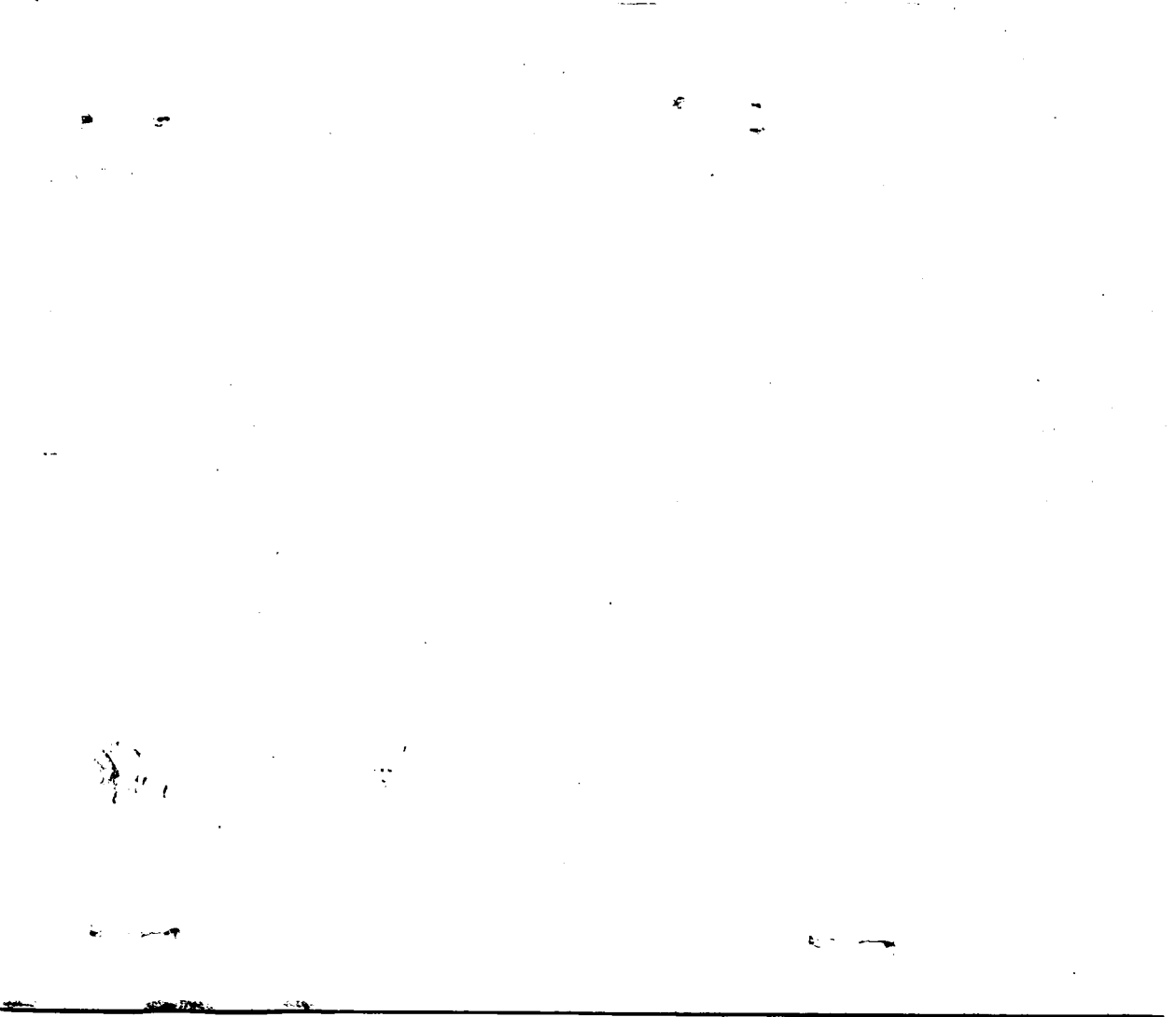
Registrar.

Registrar.

192

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.



RECEIVED MAR 31 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 25943

PLACE OF DEATH

County of Payette
City of Lewiston

Registration District No. 96

Primary Registration District No. 1029

Local Registrar's No. 2010

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Korte meier

(a) Residence. No. _____ St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. Single, Married, Widowed, or Divorced (write the word) Still Born

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 22 - 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Still Born

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston Idaho
(State or country)10. NAME OF FATHER HA. Kortemeier11. BIRTHPLACE OF FATHER (city or town) Iowa
(State or Country)12. MAIDEN NAME OF MOTHER Grace White13. BIRTHPLACE OF MOTHER (city or town) Wash
(State or Country)14. Informant HA. Kortemeier
(Address) Lewiston Ida15. Filed Jan 1, 1930 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Still Born 1930
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 2-22, 1930, to 2-22, 1930

that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Premature birth - 7 mo.

(duration) yrs. mos. ds.
CONTRIBUTORY Unknown except mother
(Secondary) had flu 2 weeks before
(duration) yrs. mos. ds.

18. Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? noWhat test confirmed diagnosis? History -(Signed) E. L. White, M. D.2-24, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Ida Date of Burial 2/22 193020. Undertaker Wm. Mortuary Address Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

179844 2

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

255-148-072-513
PLACE OF BIRTH Black Falls
County of Blaine
City of Kimberly
No. 1 St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 179975

Registration District No. Stillborn State File No. 179975
Prim. Registration District No. Person's Local Registrar's No. 179975

FULL NAME OF CHILD Royal Glenn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Boy</u>	Twins Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>2</u> <u>17</u> <u>1930</u> (Month) (Day) (Year)
-------------------------	--	---------------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 1st (a) Born alive and now living 1

Born alive but now dead one Stillborn 0

FATHER FULL NAME <u>Royal Glenn Person</u>	MOTHER FULL MAIDEN NAME <u>Edna Elizabeth Valline</u>
---	--

Residence (Usual place of abode) <u>deceased</u>	Residence (Usual place of abode) <u>Kimberly</u>
--	--

If nonresident, give place and State None

Color or race <u>white</u> Age at last Birthday <u>31</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>30</u> (Years)
---	---

Birthplace <u>Earlham Ia</u> (City and State or Country)	Birthplace <u>Colorado Springs Colo</u> (City and State or Country)
---	--

Occupation <u>None</u>	Occupation <u>Housewife</u>
------------------------	-----------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 1:30 P. M.
on the date above stated.

(Signature) C. D. Werner

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address Tim Lave Ida

Filed 3:31 19 30 Clayton G. Smith
Registrar.

1718

RECEIVED MAY 3 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho

APR 21 1930

179975

Mrs. R.G. Beeson
Kimberly

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD Lois Ellen Beeson, Jr.

PLACE OF BIRTH** Kimberly DATE OF BIRTH Feb. 14, 1930 SEX OF CHILD Male

1. Number of children born to this mother, including present birth 1
2. Number born alive and now living 1
3. Born alive but now dead
4. Number of children stillborn 1

(Please write plainly)

Information with reference to <u>FATHER</u>	Information with reference to <u>MOTHER</u>
<u>Raymond Glenn Beeson (deceased)</u> (Full name)	<u>Edna Elizabeth Talle</u> (Full Maiden name)
<u> </u> (Residence)	<u>Boise, Idaho</u> (Residence)
Age at last birthday <u>21</u>	Age at last birthday <u>21</u>
<u>Earlham, Iowa</u> (Birthplace)	<u>Boise, Idaho</u> (Birthplace)
<u> </u> (Occupation)	<u> </u> (Occupation)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C. K. Macey
C.K. Macey

Special Agent, Bureau of the Census.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69691

PLACE OF DEATH

County of Lincoln
City of Kimberly

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No. at home)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Royal Glenn Beeson(a) Residence. No. Kimberly St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 14 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
5 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Kimberly Ida
(State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Iowa

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Iowa

14. Informant Educa Taline
(Address) Kimberly

15. Filed 3-6, 1930 Eliabeth J. Smith
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from on Feb. 14, 1930, to 19

that I last saw him alive on, 1930and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH was as follows:

Still born at 9 mo.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. D. Weaver, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Louis Falls 2/15 1930

20. Undertaker Address

C. J. Groesbeck Louis Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

289-145-044-134
PLACE OF BIRTH Washington
County of Wash
City of Wheat
No. St.

MAR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 180004

Registration District No. 76 State File No.

(If born in hospital or institution
give name.)

Prim. Registration District No. 2112 Local Registrar's No. 21

FULL NAME OF CHILD Joseph Albert Shirk

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>boy</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate <u>yes</u>	Date of birth <u>Feb 25</u> 19 <u>30</u> (Month) (Day) (Year)
-------------------------	---	---	----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? no

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead. Stillborn 1

FATHER
FULL NAME Robert S Shirk

Residence (Usual place of abode) Wheat

If nonresident, give place and State.

Color or race white Age at last Birthday 45 (Years)

Birthplace Iowa
(City and State or Country)

Occupation farmer

MOTHER
FULL MAIDEN NAME Mattie M Alderman

Residence (Usual place of abode) Wheat

If nonresident, give place and State.

Color or race white Age at last Birthday 35 (Years)

Birthplace Wash
(City and State or Country)

Occupation house wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at Wheat M.
on the date above stated.

(Signature) Fasching M.D.

(Physician or midwife)

Address Wheat Idaho

Filed March 19 1930 M. R. Hamlin

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

and known cause
still born.

JUL 06 2017 X\

RECEIVED MAR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70016

PLACE OF DEATH

County of Washington
City of Weiser

Registration District No. 76
Primary Registration District No. 101C

Local Registrar's No. 13

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Albert Shirts

(a) Residence. No. Weiser Ida Route # 2 St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE wht 5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Stillborn

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Weiser
(State or country) Idah

10. NAME OF FATHER R. B. Shirts

11. BIRTHPLACE OF FATHER (city or town) Iowa
(State or Country)

12. MAIDEN NAME OF MOTHER Mattie Alderson

13. BIRTHPLACE OF MOTHER (city or town) Washington
(State or Country)

14. Informant R. B. Shirts
(Address) Weiser Ida RFD # 2

15. Filed March 14, 1930 M. H. Kamm
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb-24 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb-24, 1930, to Feb 24, 1930
that I last saw he _____ alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

still born
cause unknown

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) F. A. Schmidt, M. D.
2-24, 1930 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wann Creek Date of Burial 2-25 1930

20. Undertaker L. B. Northrup Address Weiser Ida

204

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

PARENTS

2/18000

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of Ada
City of Boise, Idaho
No. _____ St. _____
St. Alphonsus Hospital Registration District No. 2 State File No. _____
(If born in hospital or institution give name.) Prim. Registration District No. 1804 Local Registrar's No. 183
FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>X</u>	and } Number in order of birth <u>1st</u>	Legitimate? <u>yes</u>	Date of birth <u>3-12-30</u>	<u>19</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)	

What prophylactic was used to prevent Ophthalmia Neonatorum? _____
Number of child of this mother, including present birth, _____ (a) Born alive and now living _____
Born alive but now dead 0 Stillborn _____

FATHER FULL NAME <u>Wm. Oscar Bragstad,</u> <u>Boise, Idaho</u> Residence (Usual place of abode) _____ If non-resident, give place and State _____ Color or race <u>White</u> Age at last Birthday <u>40</u> (Years) Birthplace <u>S. Dakota,</u> (City and State or County) Occupation <u>Plasterer</u>	MOTHER FULL MAIDEN NAME <u>Jessie Lowe</u> <u>Boise, Idaho</u> Residence (Usual place of abode) _____ If non-resident, give place and State _____ Color or race <u>White</u> Age at last Birthday <u>35</u> (Years) Birthplace <u>Ripley, Iowa</u> (City and State or County) Occupation <u>House work</u>
--	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at _____ M.
on the date above stated.
(Signature) E. O. Callister

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address _____
Filed 7 1930 W. H. Rhoades
Registrar.

1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the situation.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.

should state CAUSE OF DEATH in plain terms, so that it may be properly classified.

Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED APR 10 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69747

PLACE OF DEATH

County of Ada
City of Boise

CERTIFICATE OF DEATH

Registration District No. 3
Primary Registration District No. 1004
(No. St. Alphonsus Hospital, Local Registrar's No. 76)

2. FULL NAME Infant Bragstad
(If death occurred in a hospital or institution, give its name instead of street and number.)
(a) Residence No. 516 N 12 St.
(Usual place of abode.)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 12, 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Boise Idaho
(State or country)

PARENTS

10. NAME OF FATHER William O. Bragstad
11. BIRTHPLACE OF FATHER (city or town) South Dakota
(State or country)
12. MAIDEN NAME OF MOTHER Jessie Olin Low
13. BIRTHPLACE OF MOTHER (city or town) South Dakota
(State or country)

14. Informant (Address) William O. Bragstad, 516 N 12 St Boise Idaho

15. Filed 3-13 1930 W. H. Rhoads Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 12, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12, 1930 to Mar. 12, 1930
that I last saw her alive on Mar. 12, 1930

and that death occurred, on the date stated above, at 11:30 p.m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Still born

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. A. Calvert M. D.
3/13 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery Date of Burial Mar. 13 1930

20. Undertaker Summers & Kufs Address Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of** (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH County of <u>Lincoln</u> City of <u>McCannon</u> No. St.		RECEIVED MAY 5 1930 STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH Registration District No. <u>84</u> State File No. <u>180229</u> Prim. Registration District No. <u>2161</u> Local Registrar's No. <u>760</u>		S
(If born in hospital or institution give name.)		FULL NAME OF CHILD <u>Stillbirth</u> (If stillborn, substitute the word "Stillbirth" for name of child)		
Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth (To be answered only in event of plural births)	Legitimate? <u>Yes</u>	Date of birth <u>Feb 8 1930</u> (Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? <u>None</u>				
Number of child of this mother, including present birth <u>1</u> (a) Born alive and now living <u>0</u> Born alive but now dead Stillborn <u>This one</u>				
FATHER FULL NAME <u>King George Hillman</u> Residence (Usual place of abode) <u>McCannon</u> If nonresident, give place and State Color or race <u>White</u> Age at last Birthday <u>27</u> (Years) Birthplace <u>Downey Idaho</u> (City and State or Country) Occupation <u>Farmer</u>		MOTHER FULL MAIDEN NAME <u>Rayona Winifred Thompson</u> Residence (Usual place of abode) <u>McCannon</u> If nonresident, give place and State Color or race <u>White</u> Age at last Birthday <u>21</u> (Years) Birthplace <u>Downey Idaho</u> (City and State or Country) Occupation <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ Stillborn } at 7 A. M.
on the date above stated.

(Signature) C. A. Rich

(Physician or midwife)

Address Lava Hot Springs Id.

Filed Apr 15 1930

1930

Mr. J. J. Fitz

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

2

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

City of _____
No. _____
Registered on District No. _____
Registration District No. _____
Date of Birth _____
Full Name of Child _____
If different, state the word "maiden" for name of child.

Sex of Child _____
Date of Birth _____
Place of Birth _____
If the child was born in a hospital, state the name of the hospital.

What prophylaxis was used to prevent (phthalitis neonatorum)?
Name of child at this address, including present birth _____
Born alive or dead _____

Parents
Name _____
Name _____
Name _____

Residence (usual place of abode) _____
If nonresident, give place and state _____

Occupation _____
If nonresident, give place and state _____

Signature of attending physician or midwife _____
Date and time of birth _____

Signature of attending physician or midwife _____
Date and time of birth _____

Signature of attending physician or midwife _____
Date and time of birth _____

Signature of attending physician or midwife _____
Date and time of birth _____

Signature of attending physician or midwife _____
Date and time of birth _____

Signature of attending physician or midwife _____
Date and time of birth _____

Where there was no attending physician or midwife, the father, householder, or other person who was present at the birth of the child, should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70112

RECEIVED MAY 5 1930
PLACE OF DEATH
County of Cannock
City of McCannon
Registration District No. 84
Primary Registration District No. 2161

Local Registrar's No. 178

(No. _____)
(If death occurred in hospital or institution, give its name instead of street and number.)

2. FULL NAME Stilbirth
(a) Residence No. McCannon Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

204

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OF RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of None
6. DATE OF BIRTH (month, day and year) Feb. 8, 1930
7. AGE Years Months Days If LESS than 1 day, hrs. or min. 0
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer None

9. BIRTHPLACE (city or town) (State or country) McCannon Idaho
10. NAME OF FATHER King George Hillman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dorsey Idaho
12. MAIDEN NAME OF MOTHER Raynora Winifred Thompson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dorsey Idaho

14. Informant C. A. Rich M.D. copy for Birth certificate
(Address) Lava Hot Springs
15. Filed Apr 15, 1930 Mar 2, 9 Feb
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 8 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from At birth to Feb 8, 1930
that I last saw him alive on Feb 2-8, 1930
and that death occurred, on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows:
Injury during birth

(duration) yrs. mos. ds.
CONTRIBUTORY Disproportion in outlet of
(Secondary) Mother (duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of _____
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C. A. Rich M. D.
2-8, 1930 (Address) Lava Hot Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial
19
20. Undertaker Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED MAY 7 1930 STATE OF IDAHO
County of Bingham DEPARTMENT OF PUBLIC WELFARE
City of Blackfoot BUREAU OF VITAL STATISTICS
No. R.D.# 2 St. 19265
Registration District No. 121 State File No. 19265
Prim. Registration District No. 2194 Local Registrar's No. 99
(If born in hospital or institution give name.)
FULL NAME OF CHILD Stillborn Murdoch
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Female Twin Triplet and Number
Child 1 or other? in order
(To be answered only in event of plural births) Legiti- mate? Yes Date of April 1 1930
(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth. 9 (a) Born alive and now living 7
Born alive but now dead 1 Stillborn This one

FATHER		MOTHER	
FULL NAME	<u>Leo D. Murdoch</u>	FULL MAIDEN NAME	<u>Francis Risetta Dance</u>
Residence (Usual place of abode)	<u>Blackfoot</u>	Residence (Usual place of abode)	<u>Blackfoot</u>
If nonresident, give place and State		If nonresident, give place and State	
Color or race <u>White</u>	Age at last Birthday <u>39</u> (Years)	Color or race <u>White</u>	Age at last Birthday <u>37</u> (Years)
Birthplace <u>Utah</u>	(City and State or Country)	Birthplace <u>Utah</u>	(City and State or Country)
Occupation <u>Farmer</u>		Occupation <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 3:45 a.m. M. on the date above stated.

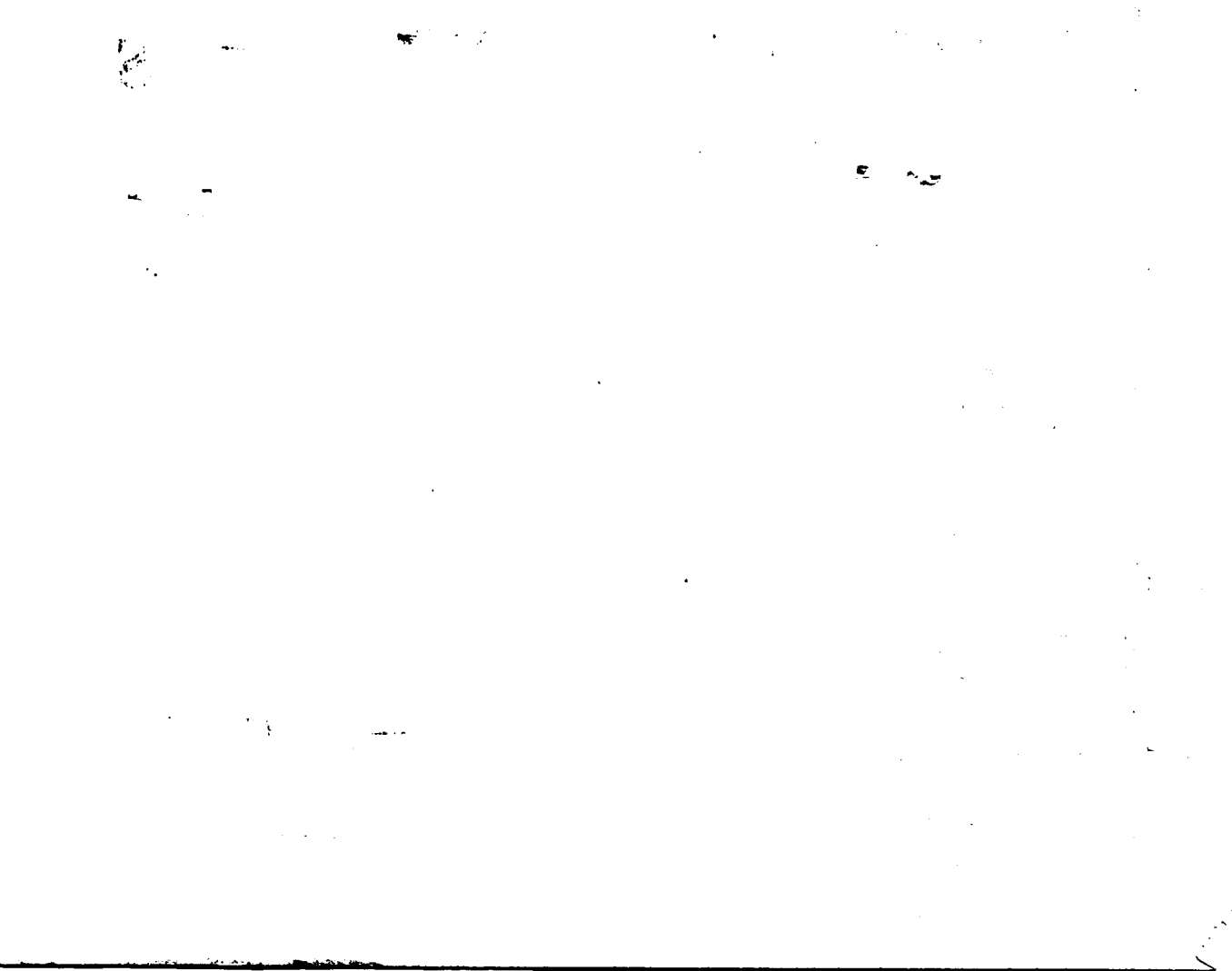
(Signature) Low Beck MD

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Blackfoot, Idaho

Filed May 3 1930 Mr. Nature Amie

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 7 1930
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70143

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194

Local Registrar's No. 49

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn Murdock
(a) Residence. No. Blackfoot R.T.D. #2 St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) _____
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____
6. DATE OF BIRTH (month, day and year) _____
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
✓ ✓ ✓ _____
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (city or town) Blackfoot (State or country) Idaho
10. NAME OF FATHER Les D Murdock
11. BIRTHPLACE OF FATHER (city or town) Marion (State or Country) Utah
12. MAIDEN NAME OF MOTHER Francis Vance
13. BIRTHPLACE OF MOTHER (city or town) Wilson (State or Country) Utah

14. Informant Les D Murdock (Address) Blackfoot R.T.D. #2

15. Filed April 1, 1930 Registrar W. H. Bates

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 1st 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/1, 1930, to 4/1, 1930
that I last saw her alive on Stillborn, 1930
and that death occurred, on the date stated above, at 3:00 a.m.
The CAUSE OF DEATH* was as follows:

Placenta Previa
Complete Central
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____
Did an operation precede death? _____ Date of _____
Was there an autopsy? no
What test confirmed diagnosis? _____
(Signed) W. W. Beck, M. D.
4/1, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Thomas Reunick Date of Burial April 1930

20. Undertaker E. J. Park Address Blackfoot

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

RECEIVED APR 25 1932

PLACE OF BIRTH

County of Bonneville
City of Edwards Falls

- STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

No. _____ St. _____

L. L. Hoep
(If born in hospital or institution
give name.)

Registration District No. 73 State File No. 180311

Prim. Registration District No. 15 Local Registrar's No. 101

FULL NAME OF CHILD

Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	{ and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>March 12</u> 19 <u>32</u> (Month) (Day) (Year)
-----------------------------	---	---	--------------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1 (a) Born alive and now living _____

Born alive but now dead 1 Stillborn _____

FATHER FULL NAME <u>Herbert C. Meppen</u>	MOTHER FULL MAIDEN NAME <u>Hilda Theodora Jensen</u>
--	---

Residence (Usual place of abode) Shelley, Idaho Residence (Usual place of abode) Shelley, Idaho

If non-resident, give place and State _____ If non-resident, give place and State _____

Color or race white Age at last Birthday 29 Color or race white Age at last Birthday 30
(Years) (Years)

Birthplace Council Bluffs, Iowa Birthplace Council Bluffs, Iowa
(City and State or County) (City and State or County)

Occupation Farmer Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 3 ¹⁰ P. M.
on the date above stated. Stillborn

(Signature) [Signature]

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Shelley, Idaho

Filed Mar 21 1932 [Signature]
Registrar.

RECEIVED APR 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No.

70168

PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME

(a) Residence. No.

(Usual place of abode)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant

(Address)

15. Filed

Mar 13, 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at 3:40 P. M.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

18. Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

20. Undertaker

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

253-129-018-243
PLACE OF BIRTH

MAY 10 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 180347

County of Canyon

City of Nampa

No. 5534462

R. F. D. #1

Registration District No. 7 State File No. 2006

(If born in hospital or institution
give name.)

Prim. Registration District No. 2006 Local Registrar's No. 77

FULL NAME OF CHILD Aubrey Paul Becker

If stillborn, substitute the word "Stillborn" for name of child

Sex of Child <u>male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>4-29-1930</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol 10%

Number of child of this mother, including present birth 2 (a) Born alive and now living 0

Born alive but now dead none Stillborn two

FATHER
FULL NAME A. Peter Becker

Residence (Usual place of abode) Nampa Rl.

If nonresident, give place and State

Color or race White Age at last Birthday 35 (Years)

Birthplace Germany (City and State of Country)

Occupation minister of the Gospel

MOTHER
FULL MAIDEN NAME Fannie Laurene Becker

Residence (Usual place of abode) Nampa Rl.

If nonresident, give place and State

Color or race White Age at last Birthday 34 (Years)

Birthplace Astoria, Ill. (City and State of Country)

Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 4:10 P. M. on the date above stated.

(Signature) J. Horton

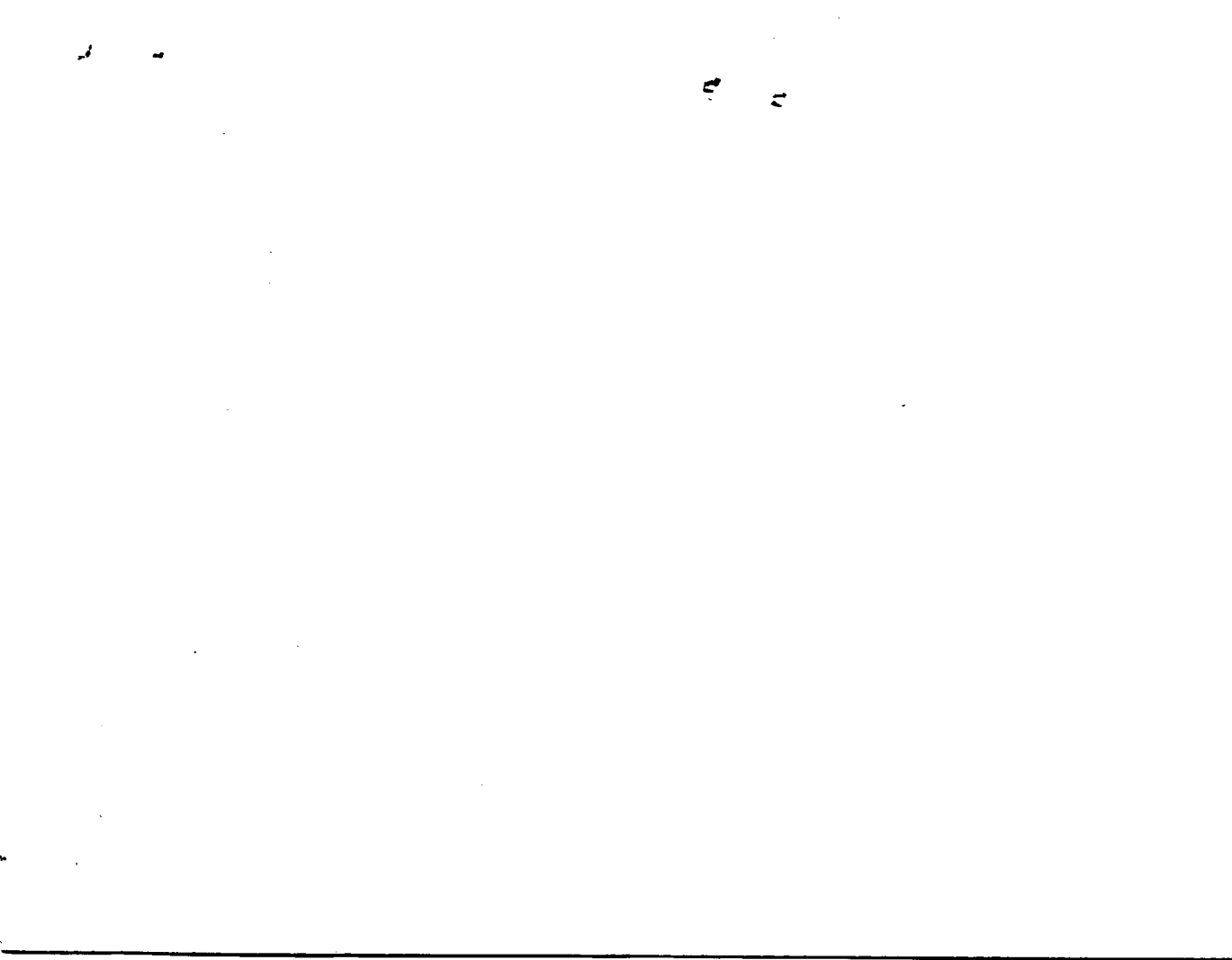
(Physician or midwife)

Address Nampa Idaho

Filed 5/2 1930 B. D. Thompson

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 70178

PLACE OF DEATH

County of Canyon
City of Nampa

CERTIFICATE OF DEATH

Registration District No. 7
Primary Registration District No. 2006
(No. _____)Local Registrar's No. 52

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Aubrey Paul Becker(a) Residence. No. Lone Star road St.(Usual place of abode.)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word.) single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____6. DATE OF BIRTH (month, day and year) April 29-1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Nampa
(State or country) Idaho

PARENTS

10. NAME OF FATHER A. P. Becker11. BIRTHPLACE OF FATHER (city or town) Germany
(State or Country)12. MAIDEN NAME OF MOTHER Fannie L. Baker13. BIRTHPLACE OF MOTHER (city or town) Illinois
(State or Country)14. Informant A. P. Becker
(Address) Nampa, Idaho15. Filled 4-30 19 30 Deft. H. May
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4-29 19 30
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 4-29 19 30 to 4-30 19 30that I last saw him alive on 4-30 and that death occurred, on the date stated above, at 4:10 p.m.*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Still bornCONTRIBUTORY (Secondary) ✓
(duration) yrs. mos. ds.18. Where was disease contracted if not at place of death? 2Did an operation precede death? ✓ Date of 4-30Was there an autopsy? ✓What test confirmed diagnosis? ✓(Signed) J. Horton M. D.
4-30 19 30 (Address) Nampa Idaho19. Place of Burial, Cremation, or Removal Katlerlawn-Nampa Date of Burial 4-30 19 3020. Undertaker W. J. Talley Address Nampa Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back.

PHYSICIAN

MARGIN RESERVED FOR BINDING

180347 N

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At Home**, and children not gainfully employed, as **At school or At Home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of** (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACED ON RECORD MAY 5 1930

County of Franklin
City of Duston Ida
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 180406

Registration District No. 27 State File No. _____
(If born in hospital or institution
give name.) Prim. Registration District No. 2119 Local Registrar's No. _____

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	{ and }	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>April 25</u> 19 <u>30</u> (Month) (Day) (Year)
----------------------------	---	---------	--------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 8 (a) Born alive and now living 7
Born alive but now dead _____ Stillborn 1

FATHER FULL NAME <u>Jacob George Caton</u> Residence (Usual place of abode) <u>Duston Ida</u> If non-resident, give place and State _____ Color or race <u>White</u> Age at last Birthday <u>45</u> (Years) Birthplace <u>Duston Ida</u> (City and State or County) Occupation <u>Sheep</u>	MOTHER FULL MAIDEN NAME <u>Estella Hedges</u> Residence (Usual place of abode) <u>Duston Ida</u> If non-resident, give place and State _____ Color or race <u>White</u> Age at last Birthday <u>45</u> (Years) Birthplace <u>Duston Ida</u> (City and State or County) Occupation <u>Housewife</u>
---	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at _____ P. M.
on the date above stated.

(Signature) Charles Horley

(Physician or midwife)

Address Duston Ida

Filed 4-29-1930 A. B. Cullen

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

2

DATE: 11/11/77

Number of all of the method including groups with (a) 2000 alive and now living

14-00000

Color of hair: _____
Color of eyes: _____
Color of skin: _____
Color of teeth: _____
Color of hair: _____
Color of eyes: _____
Color of skin: _____
Color of teeth: _____

16 _____ 17 _____

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861. It is a copy of the original letter, and is signed by Abraham Lincoln.

Address: _____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 5 1930
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76211

County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119

Local Registrar's No.

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn Paton Baby

(a) Residence. No. _____ St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE White	5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year) April 29, 1930		
7. AGE Years	Months	Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (city or town) Preston, Idaho
(State or country)

PARENTS

10. NAME OF FATHER Jacob Alonzo Paton
11. BIRTHPLACE OF FATHER (city or town) Preston, Idaho (State or Country)
12. MAIDEN NAME OF MOTHER Estella Geddes
13. BIRTHPLACE OF MOTHER (city or town) Preston, Idaho (State or Country)

14. Informant J. A. Paton
(Address) Preston, Idaho

15. Filed _____, 19____
R. P. Quells
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April 29 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
that I last saw h_____ alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:
Cause unknown

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? _____ Date of _____
Was there an autopsy? _____
What test confirmed diagnosis?
(Signed) Eugene H. Kelsey, M. D.
April 30 1930 (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal _____ Date of Burial _____
19

20. Undertaker _____ Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFA. THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

793-128-025-793
PLACE OF BIRTH
RECEIVED APR 28 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Idaho

City of Grangeville

CERTIFICATE OF BIRTH 180524

No. _____ St. _____ Registration District No. _____ State File No. _____

Hospital _____ Primary Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD Edward Walter Gillett
(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin Triplet or other? _____ } and { Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>yes</u>	Date of birth <u>3-28-1930</u> (Month) (Day) (Year)
--------------------------	--	-----------------------------	---

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER		MOTHER	
FULL NAME <u>Roy Gillett</u>	FULL MAIDEN NAME <u>Caroline Effie Gillette</u>		
RESIDENCE <u>Grangeville, Idaho</u>	RESIDENCE <u>Grangeville, Idaho</u>		
COLOR <u>white</u>	COLOR <u>white</u>		
AGE AT LAST BIRTHDAY <u>34</u> (Years)	AGE AT LAST BIRTHDAY <u>37</u> (Years)		
BIRTHPLACE <u>Nebraska</u>	BIRTHPLACE <u>Oregon</u>		
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 6 ¹⁵/₁₀ M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

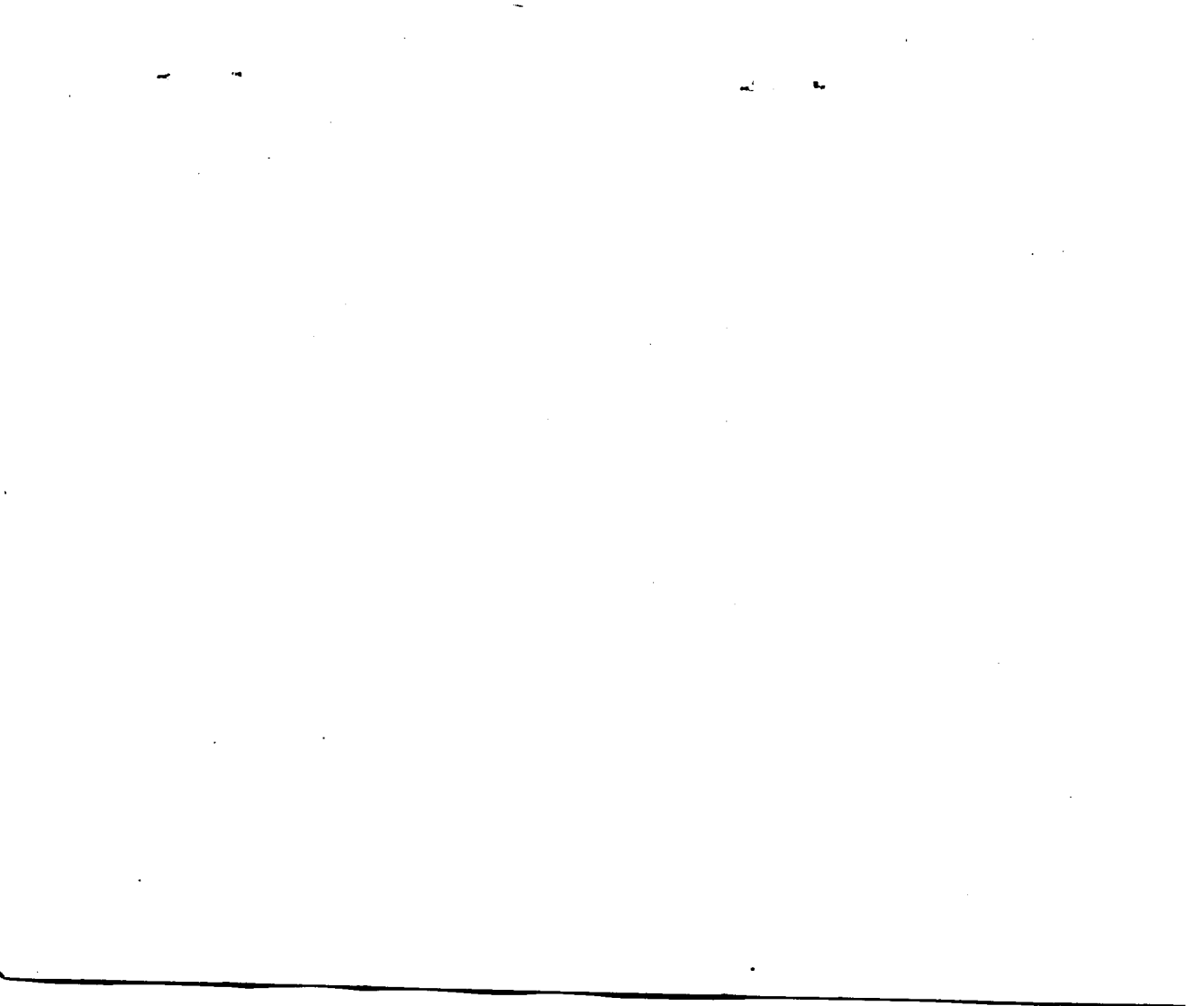
(Signature) Dr. J. P. Weber

(Physician or ~~midwife~~)

Address Grangeville, Ida

Filed April 25 1930 Bessie M. Lipper
State Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 8 1930

PLACE OF DEATH

County of Idaho
City of Grangerville

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL-STATISTICS
CERTIFICATE OF DEATH

Registration District No. 103

Primary Registration District No. 2181

(No. Home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 70256

Local Registrar's No. 12

2. FULL NAME Baby Gillitt

(a) Residence. No. C St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced Still-born

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 3-28-30

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Still-born

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Grangerville
(State or country)

10. NAME OF FATHER Roy Gillitt

11. BIRTHPLACE OF FATHER (city or town) Nebraska
(State or Country)

12. MAIDEN NAME OF MOTHER Carrie Gillitt

13. BIRTHPLACE OF MOTHER (city or town) Oregon
(State or Country)

14. Informant Roy Gillitt
(Address)

15. J. J. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 28, 1930, to 3-28, 1930, that I last saw him alive on 3-28, 1930 and that death occurred, on the date stated above, at 6 P.m.

The CAUSE OF DEATH* was as follows: Hard labor caused by previous operation to mother uterus. Brought down to baby. (duration) 0 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Chipman M. D.

3-28, 1930 (Address) Grangerville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grangerville Date of Burial 3-30 1930

20. Undertaker Vassar Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

APR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

180533

County of Jerome
City of Jerome
No. _____ St. _____

Registration District No. 18 State File No. _____

(If born in hospital or institution
give name.)

Prime Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD not named Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Boy</u>	Twin <u>Triplet</u> or other? _____	and {	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>Feb 25</u> <u>1930</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth _____ (a) Born alive and now living 4

Born alive but now dead _____ Stillborn one

FULL NAME <u>FATHER</u> <u>Walter M. O'Leary</u>	FULL NAME <u>MOTHER</u> <u>Emma J. White</u>
--	--

Residence (Usual place of abode) Jerome, Idaho Jerome, Idaho

If non-resident, give place and State _____ If non-resident, give place and State _____

Color or race White Age at last Birthday 72 (Years) White Age at last Birthday 42 (Years)

Birthplace Jerome, Idaho (City and State or County) West Va. (City and State or County)

Occupation farmer Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive 7 9 M.
on the date above stated. Stillborn at

Labor at 6 1/2 mo.
*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Paul Price
Physician
(Physician or midwife)

Address Jerome, Idaho

Filed 4 3 1930 Chas. H. Wells
me Registrar.

Caus. Hepatic Colic

DEPARTMENT OF JUSTICE
BUREAU OF INVESTIGATION

INVESTIGATION OF

Standing Order No. 100-100000
Investigation of

Investigation of the

Investigation of the

Investigation of the

Investigation of the

Investigation of the

Investigation of the

Investigation of the

Investigation of the

Investigation of the

Investigation of the

Investigation of the

INVESTIGATION OF

INVESTIGATION OF

INVESTIGATION OF

INVESTIGATION OF

INVESTIGATION OF

INVESTIGATION OF

INVESTIGATION OF

INVESTIGATION OF

INVESTIGATION OF

INVESTIGATION OF

INVESTIGATION OF

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-10-2000 BY 60322 UCBAW

RECEIVED MAY 26 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho MAY 20 1930

Mrs. W. M. Otis
Jerome

180533
BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD No Name Mature Birth Stillborn

PLACE OF BIRTH** Jerome DATE OF BIRTH Feb. 25, 1930 SEX OF CHILD Male

1. Number of children born to this mother, including present birth _____
2. Number born alive and now living _____
3. Born alive but now dead _____
4. ~~Number of children stillborn~~ _____

(Please write plainly)

Information with reference to
FATHER

Information with reference to
MOTHER

Walter M. Otis
(Full name)

Emma M. Otis
(Full Maiden name)

Jerome
(Residence)

Jerome
(Residence)

Age at last birthday _____

Age at last birthday _____

(Birthplace)

(Birthplace)

(Occupation)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C. K. Macey

C.K. Macey
Special Agent, Bureau of the Census.

743 206 030-743
PLACE OF BIRTH
RECEIVED APR 17 1930STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Form V. S. No. 110-211-2-11

S

County of BlaineCity of SalmonRegistration District No. 41File No. 180641

No. St.

Primary Registration District No. 2116

Registered No.

Hospital Rose

FULL NAME OF CHILD

Sex of Child <u>Female</u>	Twin Triplet or other? <u>No</u>	and Number in order of birth <u>No.</u>	Legitimate? <u>No.</u>	Date of Birth <u>4-6-30</u> (Month) (Day) (Year)
----------------------------	----------------------------------	---	------------------------	---

FULL NAME <u>Byron Haddy</u>	FATHER
RESIDENCE <u>Baker, Ida</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>16</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Ranchman</u>	

FULL MAIDEN NAME <u>Nellie Putney</u>	MOTHER
RESIDENCE <u>Montana</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>16</u> (Years)
BIRTHPLACE <u>Montana</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth OneNumber of children of this mother now living, including present birth One

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated.

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) C. J. Stratton, M.D.

Given names added from a supplemental report.

Address Salmon, IdahoFiled April 30

Registrar

Registrar

2

1

1

1

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED APR 17 1930

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

County of Lemhi
City of Salmon

Registration District No. 41Primary Registration District No. 2116(No. Rose Hospital)

St.)

File No. 70222

Registered No. _____

If death occurred in a hospital institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ortriley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

4-6-930
(Month) (Day) (Year)

7. AGE

Full term.
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Byron Hadley

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Nellie Ortriley

13. BIRTHPLACE OF MOTHER

(State or Country)

Montana

14. THE ABOVE ARE TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

State of Idaho
Salmon, Idaho

15.

Filed April 10 1930

Chas Bellamy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4-6-30
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191,
that I last saw h. alive on 191,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Full term.
trauma in delivery of
prolonged presentation.
(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Signed) P. J. Thompson M. D.
4/7/30 (Address) Salmon, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence Lemhi, Idaho

19. PLACE OF BURIAL OR REMOVAL

Salmon, Idaho

DATE OF BURIAL

4-9-30

20. UNDERTAKER

J. H. Rose

ADDRESS

Salmon, Idaho

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of Minidoka MAY 8 1930 STATE OF IDAHO
City of Rupert DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH **S180670**
No. St.

Registration District No. 19 State File No.
(If born in hospital or institution give name.) Idm. Registration District No. 2015 Local Registrar's No. 56
FULL NAME OF CHILD "Stillbirth"
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>female</u>	Twin Triplet or other? (To be answered only in event of plural births)	{ and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>3</u> <u>18</u> <u>1930</u> (Month) (Day) (Year)
-------------------------------	---	---	--------------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth one (a) Born alive and now living 0

Born alive but now dead none Stillborn one

FATHER	MOTHER
FULL NAME <u>Warley D. Head</u>	FULL MAIDEN NAME <u>Viola M. Briggs</u>

Residence (Usual place of abode) <u>Rupert, Ida.</u>	Residence (Usual place of abode) <u>Rupert, Ida.</u>
--	--

If non-resident, give place and State

Color or race <u>white</u> Age at last Birthday <u>29</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>22</u> (Years)
---	---

Birthplace <u>Sperry's Ferry Va.</u> (City and State or County)	Birthplace <u>La Belle Va.</u> (City and State or County)
--	--

Occupation <u>Shop Raising</u>	Occupation <u>house wife</u>
--------------------------------	------------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn Beom-alina at 11:50 M.
on the date above stated.

(Signature) Reuben Ferguson, M.D.

(Physician or midwife)

Address Rupert, Idaho

Filed 5-5-1930 Elmer

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

DEPARTMENT OF JUSTICE
BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

Washington District No. _____
 Field Office District No. _____
 File No. _____

DATE OF BIRTH _____
 PLACE OF BIRTH _____
 SEX _____
 COLOR _____
 HEIGHT _____
 WEIGHT _____
 EYES _____
 HAIR _____
 BUILD _____
 TENDENCY _____
 OCCUPATION _____
 EDUCATION _____
 MARITAL STATUS _____
 RELIGION _____
 RACE _____
 ETHNICITY _____
 SOCIAL SECURITY NUMBER _____
 ALIEN REGISTRATION NUMBER _____
 PASSPORT NUMBER _____
 VISA NUMBER _____
 DRIVER'S LICENSE NUMBER _____
 MILITARY SERVICE _____
 MENTAL RECORD _____
 CRIMINAL RECORD _____
 FINGERPRINTS _____
 PHOTOGRAPH _____
 SIGNATURE _____
 ADDRESS _____
 PHONE NUMBER _____
 TELETYPE NUMBER _____
 TELEPHONE NUMBER _____
 MAILING ADDRESS _____
 MAILING PHONE NUMBER _____
 MAILING TELEPHONE NUMBER _____
 MAILING TELETYPE NUMBER _____

EDUCATION _____
 OCCUPATION _____
 MARITAL STATUS _____
 RELIGION _____
 RACE _____
 ETHNICITY _____
 SOCIAL SECURITY NUMBER _____
 ALIEN REGISTRATION NUMBER _____
 PASSPORT NUMBER _____
 VISA NUMBER _____
 DRIVER'S LICENSE NUMBER _____
 MILITARY SERVICE _____
 MENTAL RECORD _____
 CRIMINAL RECORD _____
 FINGERPRINTS _____
 PHOTOGRAPH _____
 SIGNATURE _____
 ADDRESS _____
 PHONE NUMBER _____
 TELETYPE NUMBER _____
 TELEPHONE NUMBER _____
 MAILING ADDRESS _____
 MAILING PHONE NUMBER _____
 MAILING TELEPHONE NUMBER _____
 MAILING TELETYPE NUMBER _____

EDUCATION _____
 OCCUPATION _____
 MARITAL STATUS _____
 RELIGION _____
 RACE _____
 ETHNICITY _____
 SOCIAL SECURITY NUMBER _____
 ALIEN REGISTRATION NUMBER _____
 PASSPORT NUMBER _____
 VISA NUMBER _____
 DRIVER'S LICENSE NUMBER _____
 MILITARY SERVICE _____
 MENTAL RECORD _____
 CRIMINAL RECORD _____
 FINGERPRINTS _____
 PHOTOGRAPH _____
 SIGNATURE _____
 ADDRESS _____
 PHONE NUMBER _____
 TELETYPE NUMBER _____
 TELEPHONE NUMBER _____
 MAILING ADDRESS _____
 MAILING PHONE NUMBER _____
 MAILING TELEPHONE NUMBER _____
 MAILING TELETYPE NUMBER _____

EDUCATION _____
 OCCUPATION _____
 MARITAL STATUS _____
 RELIGION _____
 RACE _____
 ETHNICITY _____
 SOCIAL SECURITY NUMBER _____
 ALIEN REGISTRATION NUMBER _____
 PASSPORT NUMBER _____
 VISA NUMBER _____
 DRIVER'S LICENSE NUMBER _____
 MILITARY SERVICE _____
 MENTAL RECORD _____
 CRIMINAL RECORD _____
 FINGERPRINTS _____
 PHOTOGRAPH _____
 SIGNATURE _____
 ADDRESS _____
 PHONE NUMBER _____
 TELETYPE NUMBER _____
 TELEPHONE NUMBER _____
 MAILING ADDRESS _____
 MAILING PHONE NUMBER _____
 MAILING TELEPHONE NUMBER _____
 MAILING TELETYPE NUMBER _____

EDUCATION _____
 OCCUPATION _____
 MARITAL STATUS _____
 RELIGION _____
 RACE _____
 ETHNICITY _____
 SOCIAL SECURITY NUMBER _____
 ALIEN REGISTRATION NUMBER _____
 PASSPORT NUMBER _____
 VISA NUMBER _____
 DRIVER'S LICENSE NUMBER _____
 MILITARY SERVICE _____
 MENTAL RECORD _____
 CRIMINAL RECORD _____
 FINGERPRINTS _____
 PHOTOGRAPH _____
 SIGNATURE _____
 ADDRESS _____
 PHONE NUMBER _____
 TELETYPE NUMBER _____
 TELEPHONE NUMBER _____
 MAILING ADDRESS _____
 MAILING PHONE NUMBER _____
 MAILING TELEPHONE NUMBER _____
 MAILING TELETYPE NUMBER _____

EDUCATION _____
 OCCUPATION _____
 MARITAL STATUS _____
 RELIGION _____
 RACE _____
 ETHNICITY _____
 SOCIAL SECURITY NUMBER _____
 ALIEN REGISTRATION NUMBER _____
 PASSPORT NUMBER _____
 VISA NUMBER _____
 DRIVER'S LICENSE NUMBER _____
 MILITARY SERVICE _____
 MENTAL RECORD _____
 CRIMINAL RECORD _____
 FINGERPRINTS _____
 PHOTOGRAPH _____
 SIGNATURE _____
 ADDRESS _____
 PHONE NUMBER _____
 TELETYPE NUMBER _____
 TELEPHONE NUMBER _____
 MAILING ADDRESS _____
 MAILING PHONE NUMBER _____
 MAILING TELEPHONE NUMBER _____
 MAILING TELETYPE NUMBER _____

EDUCATION _____
 OCCUPATION _____
 MARITAL STATUS _____
 RELIGION _____
 RACE _____
 ETHNICITY _____
 SOCIAL SECURITY NUMBER _____
 ALIEN REGISTRATION NUMBER _____
 PASSPORT NUMBER _____
 VISA NUMBER _____
 DRIVER'S LICENSE NUMBER _____
 MILITARY SERVICE _____
 MENTAL RECORD _____
 CRIMINAL RECORD _____
 FINGERPRINTS _____
 PHOTOGRAPH _____
 SIGNATURE _____
 ADDRESS _____
 PHONE NUMBER _____
 TELETYPE NUMBER _____
 TELEPHONE NUMBER _____
 MAILING ADDRESS _____
 MAILING PHONE NUMBER _____
 MAILING TELEPHONE NUMBER _____
 MAILING TELETYPE NUMBER _____

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
 DATE 10-10-2001 BY 60322 UCBAW/BJS/STP

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 11 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72858

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2015

Local Registrar's No. 64

(No. 1306)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Still Born

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Child</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year)		
7. AGE <u>1</u> Years	<u>0</u> Months	<u>0</u> Days
LESS than 1 day, hrs. or min. <u>Still Born</u>		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Child</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u> </u> (c) Name of employer		

9. BIRTHPLACE (city or town) (State or country) <u>Rupert Idaho</u>
10. NAME OF FATHER <u>W. N. Head</u>
11. BIRTHPLACE OF FATHER (city or town) (State or Country) <u>Virginia</u>
12. MAIDEN NAME OF MOTHER <u>Viola Ennis</u>
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) <u>Idaho</u>

14. Informant <u>W. N. Head</u> (Address) <u>Rupert Idaho</u>
15. Filed <u>Nov. 6, 1930</u> <u>E. E. Elmore</u> Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH <u>Mar 18 1930</u> (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from <u>Mar 18, 1930</u> to <u>Mar 18, 1930</u> that I last saw him alive on <u>Still Born</u> , 19 <u>30</u> and that death occurred, on the date stated above, at <u>11:30 A.</u> m. The CAUSE OF DEATH* was as follows: <u>Union on umbilical cord.</u> <u>(Cord wrapped around child neck</u> <u>twice & pressure on some cut</u> <u>off circulation.</u> (duration) yrs. mos. ds. CONTRIBUTORY (Secondary) <u> </u> (duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? Did an operation precede death? <u>no</u> Date of <u> </u> Was there an autopsy? <u>no</u> What test confirmed diagnosis? (Signed) <u>Robert Brown</u> , M. D. <u>Rupert, Idaho</u> , 19 <u>30</u> (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal <u>Rupert Cemetery</u>	Date of Burial <u>Mar 19 1930</u>
20. Undertaker <u>W. D. Woodman</u>	Address <u>Rupert</u>

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

PLACED ON FILE MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

180772

(If born in hospital or institution give name.)

Registration District No. 727 Prim. Registration District No. 176 Local Registrar's No. 33

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>4-3-</u> 19 <u>30</u> (Month) (Day) (Year)
-------------------------------	---	-----	--------------------------	---------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 7 (a) Born alive and now living 3
Born alive but now dead 3 Stillborn 1

FATHER FULL NAME <u>O. J. Mardock</u> Residence (Usual place of abode) <u>Driggs</u> If non-resident, give place and State Color or race <u>W.</u> Age at last Birthday <u>41</u> (Years) Birthplace <u>Henrieville, Utah</u> (City and State or County) Occupation <u>Miner</u>	MOTHER FULL MAIDEN NAME <u>Jessie Harriman</u> Residence (Usual place of abode) <u>Driggs</u> If non-resident, give place and State Color or race <u>W.</u> Age at last Birthday <u>38</u> (Years) Birthplace <u>Henrieville, Utah</u> (City and State or County) Occupation <u>H.</u>
--	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 8:30 P. M. on the date above stated. Stillborn

(Signature) W. J. Parkinson

(Physician or midwife)

Address Driggs, Idaho
Filed 5-2- 1930 Martha Marker Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

20

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70328

PLACE OF DEATH

County of Teton
City of Driggs R.D. 2

Registration District No. 77
Primary Registration District No. 2176

Local Registrar's No. 7

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillbirth

(a) Residence. No. _____ St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Driggs, R.D. 2
(State or country) Idaho

10. NAME OF FATHER O. F. Murdock

11. BIRTHPLACE OF FATHER (city or town) Lehi
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Jean Harriman

13. BIRTHPLACE OF MOTHER (city or town) Hennington
(State or Country) Utah

14. Informant O. F. Murdock
(Address) Driggs, R.D. 2, Idaho

15. Filed 5-2-30, 1930 Martina Morker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 - 3 - 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____.

The CAUSE OF DEATH* was as follows:

Unknown (unautopsied)

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) R. J. Harrison M. D._____, 19____ (Address) Driggs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Bates, Idaho Date of Burial 4-4-1930

20. Undertaker _____ Address _____

206

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH **IDAHO** MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S180773

County of Teton
City of Victor
No. 1 St. 1

Registration District No. 77 State File No. 1

(If born in hospital or institution
give name.)

Prim. Registration District No. 2176 Local Registrar's No. 31

FULL NAME OF CHILD Stickman

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in case of plural births)	{ and } Number in order of birth	Legiti- mate? <u>+</u>	Date of birth <u>4-5-1930</u> (Month) (Day) (Year)
--------------------------	--	--	---------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead _____ Stillborn 1

FATHER FULL NAME <u>Geo. F. Shatten</u>	MOTHER FULL MAIDEN NAME <u>Medrie Hatch</u>
--	--

Residence (Usual place of abode) <u>Victor</u>	Residence (Usual place of abode) <u>Victor</u>
--	--

If non-resident, give place and State _____	If non-resident, give place and State _____
---	---

Color or race <u>W.</u> Age at last Birthday <u>33</u> (Years)	Color or race <u>W.</u> Age at last Birthday <u>32</u> (Years)
--	--

Birthplace <u>Logan, Utah</u> (City and State or County)	Birthplace <u>Victor, Ida</u> (City and State or County)
--	--

Occupation <u>Farmer</u>	Occupation <u>H. W.</u>
--------------------------	-------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 9:00 P. M.
on the date above stated.

(Signature) G. J. Mackinson

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address A. J. Berkenson Driggs Ida

Filed 5-2-1930 Martha Marker
Registrar.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

FILE NO. OF RECORD

This of _____
County of _____

Birth of _____
Child of _____
Parents _____

Prim. Registration District No. _____
Local Registration No. _____

FULL NAME OF CHILD

(If father or mother the word "child" for name of child)

Sex of _____
Date of Birth _____
Time of Birth _____
Place of Birth _____
Month _____
Day _____
Year _____

What prophylactic was used to prevent Ophtalmia neonatorum?

Number of child in this mother, including present birth _____

Now alive and how born _____

FATHER _____
MOTHER _____
Name _____

Place of birth _____

Place of birth _____

Age at last birthday _____

Birthplace _____

City and State or County _____

Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

Now alive

I hereby certify that I attended the birth of this child, who was _____
on the date above stated.

(Signature)

(Physician or midwife)

Address

When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

These should be filled out in case of stillbirth.

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70327

PLACE OF DEATH

County of TetonCity of VictorRegistration District No. 77Primary Registration District No. 2176Local Registrar's No. 6(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Stillbirth

(a) Residence. No. _____ St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Male 4. COLOR OR RACE W 5. Single, Married, Widowed, or Divorced (write the word) Single5a. If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Victor, Idaho
(State or country)10. NAME OF FATHER Geo F Shotton11. BIRTHPLACE OF FATHER (city or town) Logan
(State or Country) Utah12. MAIDEN NAME OF MOTHER Mattie Hutch13. BIRTHPLACE OF MOTHER (city or town) Victor
(State or Country) Idaho14. Informant Geo F. Shotton
(Address) Victor, Idaho15. Filed 5-2-, 1930 Martina Marker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4-5-1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Unknown (assumed)

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) H. H. Harrison M. D._____, 19____ (Address) Logan, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Victor, Idaho 4-6-1930

20. Undertaker Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

314-207042-844
PLACE OF BIRTH Idaho MAY 7 1930
County of Blaine
City of Buhl
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH **S180821**

(If born in hospital or institution give name.)
Registration District No. 39 State File No. _____
Prim. Registration District No. 2687 Local Registrar's No. _____
FULL NAME OF CHILD Mary Elizabeth Cammock
(If stillborn substitute the word "Stillbirth" for name of child)

Sex of Child <u>7</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u> }	Legitimate <u>Yes</u>	Date of birth <u>4-7-1930</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead _____ Stillborn _____

FATHER FULL NAME <u>Francis Cammock</u>	MOTHER FULL MAIDEN NAME <u>Sarah Hudson</u>
--	--

Residence (Usual place of abode) Buhl

If nonresident, give place and State _____

Color or race W Age at last Birthday 23 (Years)

Birthplace Cpls (City and State or Country)

Occupation Laborer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

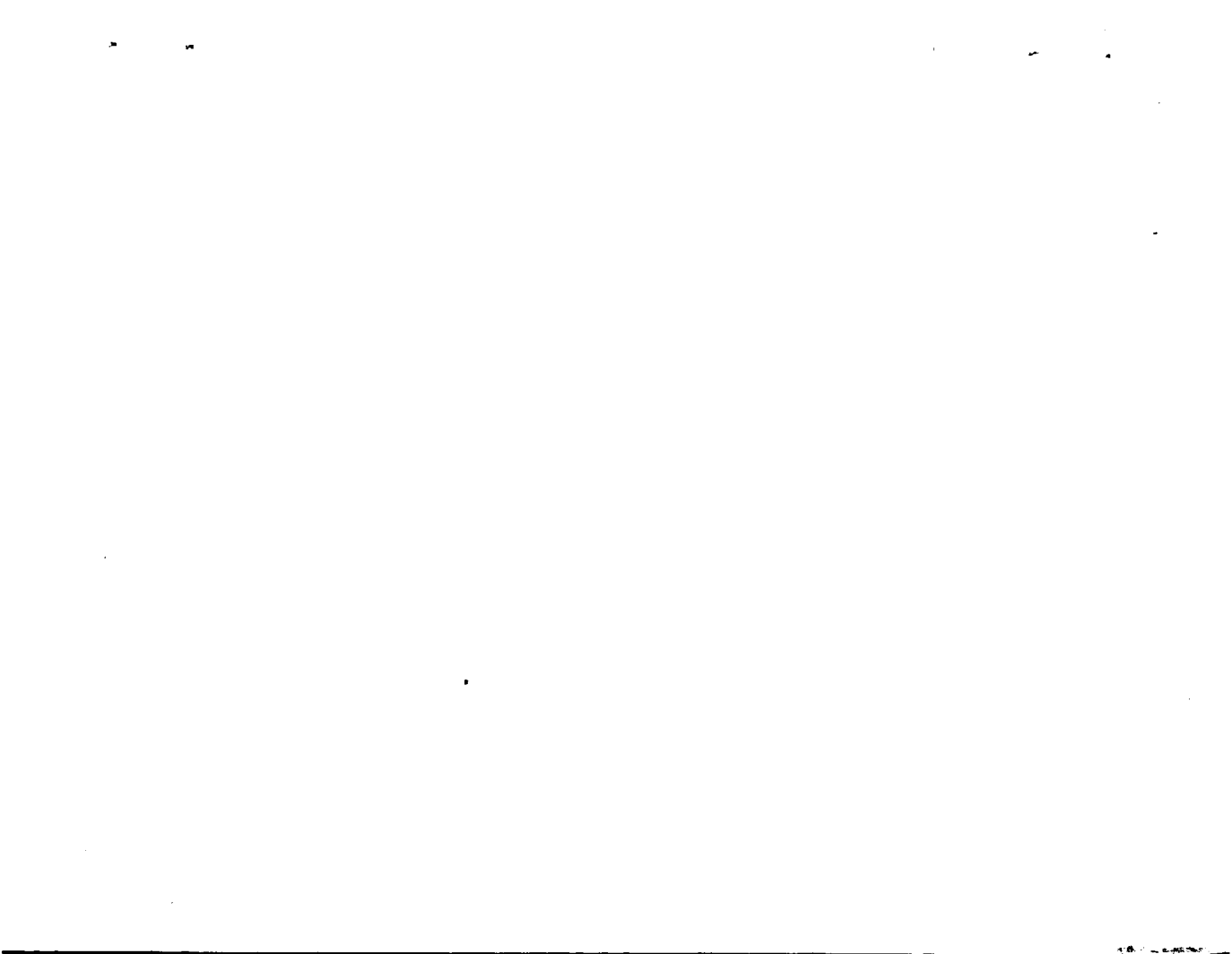
I hereby certify that I attended the birth of this child, who was Stillborn at 4:55 M.
on the date above stated.

(Signature) E. H. Berryman

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Buhl, Ida
Physician or midwife

Filed 4-30 1930 J. H. Murphy Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

PHYSICIAN

RECEIVED MAY 7 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70331

PLACE OF DEATH

County of Latah
City of Buhl

CERTIFICATE OF DEATH

Registration District No. 39
Primary Registration District No. 2087

Local Registrar's No. 159 e

2. FULL NAME

Mary Elizabeth Cummack

(a) Residence. No.

St.

(Usual place of abode.)
Length of residence in city or town where death occurred. ✓ yrs. ✓ mos. ✓ ds. How long in U. S. if of foreign birth? ✓ yrs. ✓ mos. ✓ ds. (If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 7 1930

7. AGE Years ~ Months ~ Days ~ If LESS than 1 day, ~ hrs. or ~ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Buhl Idaho
(State or country)

10. NAME OF FATHER Francis Cummack

11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Arthy Kussner

13. BIRTHPLACE OF MOTHER (city or town) Buhl - Idaho
(State or Country)

14. Informant C. Johnson
(Address) Buhl, Ida.

15. Filed 4-17 1930
Registrar. J. H. Murphy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4-7-30
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 7 30 to Apr 7 30, 1930
that I last saw died during delivery 1930
and that death occurred, on the date stated above, at 4 55 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Microcephalus - failure of devel
opment of occipital region

(duration) ~ yrs. ~ mos. ~ ds.

CONTRIBUTORY
(Secondary)

(duration) ~ yrs. ~ mos. ~ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) E. H. Barry M. D.
4-7-30 (Address) Buhl

19. Place of Burial, Cremation, or Removal Buhl Idaho Date of Burial 4/7 1930

20. Undertaker C. Johnson Address Buhl Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Saleman, (b) Grocery;** (a) **Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc.** Women at home, who are engaged in the duties of the household only (not paid **House-keepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At Home**, and children not gainfully employed, as **At school or At Home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia:** **Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.,** **Carcinoma, Sarcoma, etc.,** of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED APR 19 1930

County of Valley

City of Cascade

No. 959-209-043523St.

Registration District No. 15

File No.

CERTIFICATE OF BIRTH **S** 180858

Hospital

Primary Registration District No.

Registered No.

FULL NAME OF CHILD

Infant Reid—Still Born
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes.</u>	Date of birth <u>Mar 9 - 1930</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	------------------------------	---

What bacteriocidal solution was used in eyes?

Number of child of this mother, including present birth 4, Number of children of this mother now living, including present birth 2

FATHER
FULL NAME Sam Reid
RESIDENCE Cascade, Idaho
COLOR White AGE AT LAST BIRTHDAY 43 (Years)
BIRTHPLACE North Carolina
OCCUPATION Miner

MOTHER
FULL MAIDEN NAME Helena Strand
RESIDENCE Cascade, Idaho
COLOR White AGE AT LAST BIRTHDAY 20 (Years)
BIRTHPLACE Carey Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child on the date above stated.

Still Born at 4 P.M.
(Born or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Sam Reid
Father
(Physician or midwife)

Give names added from a supplemental report.

Address

Cascade, Idaho.

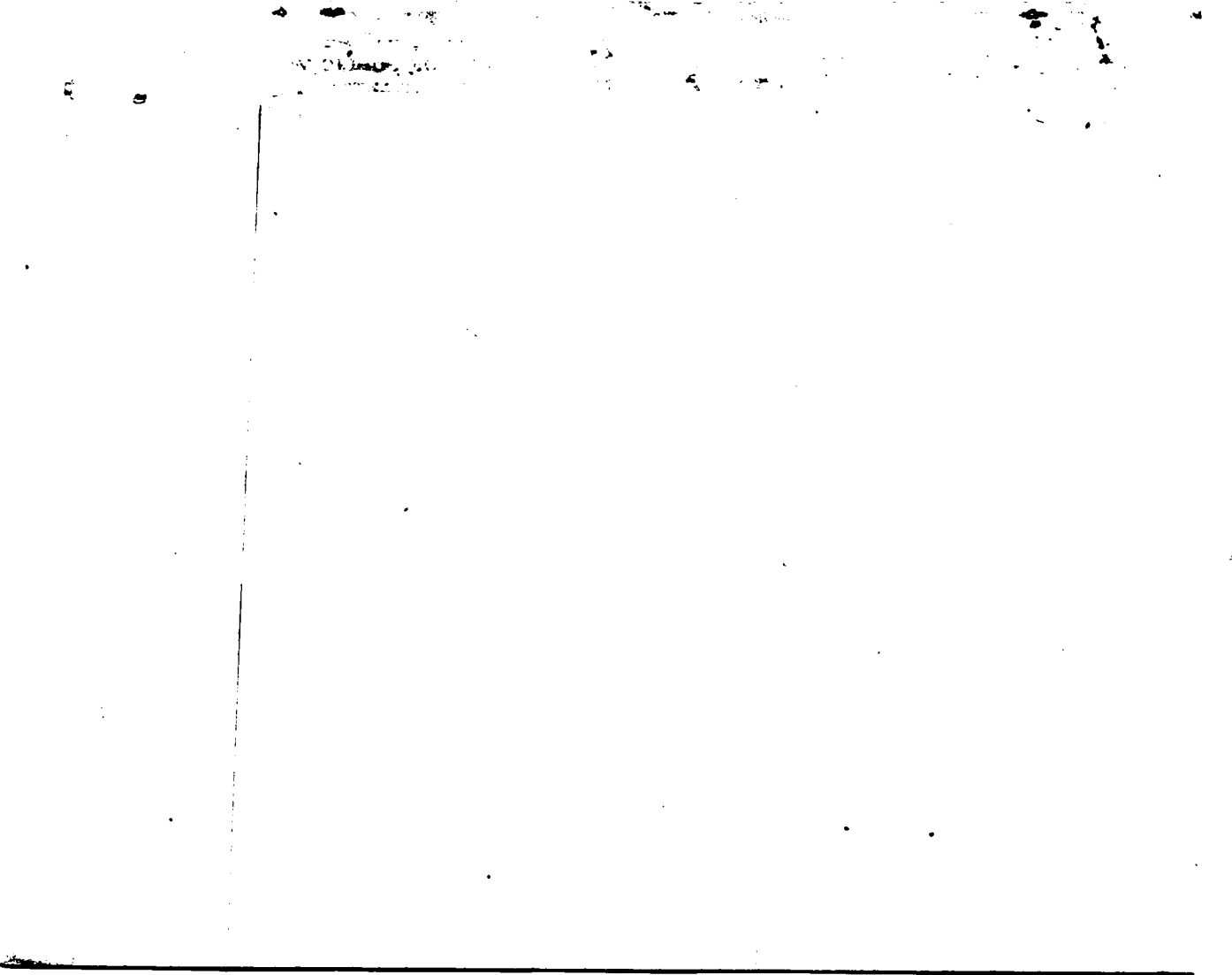
Filed

192

Stella Case

Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 19 1930
RECEIVED JUN 21 1930
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71297

County of Valley
City of Cascade

Registration District No. 15

Primary Registration District No.

Local Registrar's No.

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Reid -

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 9th 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Cascade, Ida (State or country)

10. NAME OF FATHER Sam. Reid

11. BIRTHPLACE OF FATHER (city or town) Franklin, N. C. (State or Country)

12. MAIDEN NAME OF MOTHER Helen Gustafson

13. BIRTHPLACE OF MOTHER (city or town) Carey, Idaho (State or Country)

14. Informant Sam Reid (Address) Cascade, Ida

15. Filed March 9, 1930 Stella Cain, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 9 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still birth

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Joseph E. Ward M. D.

6/19/30, 19____ Address Cascade, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Alpha - Idaho Date of Burial 3/10 1930

20. Undertaker Name - Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED MAY 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Madison
City of Rebberg

No. 343-220-033-294 St.

(If born in hospital or institution
give name.)

Registration District No. 100 State File No. 180873

Prim. Registration District No. 2178 Local Registrar's No. 83

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate?	Date of birth <u>April 20</u> 19 <u>30</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 4 (a) Born alive and now living 1

Born alive but now dead 2 Stillborn 1

FATHER	MOTHER
FULL NAME <u>Mark Lutz</u>	FULL MAIDEN NAME <u>Louise Simpson</u>

Residence (Usual place of abode) Rebberg

If non-resident, give place and State _____

Color or race W Age at last Birthday 23 (Years)

Birthplace Rebberg, Id. (City and State or County)

Occupation Section Foreman

Residence (Usual place of abode) Rebberg

If non-resident, give place and State _____

Color or race W Age at last Birthday 20 (Years)

Birthplace Salt Lake City, Ut. (City and State or County)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at _____ M.
on the date above stated.

(Signature) H. B. Rigby
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address _____
Filed 5/15 1930 W. Young Registrar.

STATE OF NEW YORK
DEPARTMENT OF SOCIAL SERVICES
BUREAU OF CHILD PROTECTION

Registration District No. _____ State of New York
 Birth Registration District No. _____
 (All children, whether or not registered, for whom a birth certificate is required)

Child's Name: _____
 Date of Birth: _____
 Sex: _____
 (If deceased, state date of death)

What person or persons was/were named to parent (Optimum: Name and address)?
 (a) _____

Number of child at birth, including deceased child _____
 Born alive but now dead _____
 Stillborn _____

Place of Birth: _____
 (If born in New York, state county)
 Date of Birth: _____
 Age at last birthday: _____

Color of hair: _____
 Color of eyes: _____
 Birthplace: _____
 (City and State or County)
 Occupation: _____
 (If deceased, state date of death)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who was _____
 on the _____ day of _____ (Month) _____

Address: _____
 (If there was no attending physician or midwife, state the name and address of the person who attended the birth of the child)
 Signed: _____

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD AS KEPT IN THE OFFICE OF THE CLERK OF THE COUNTY OF _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH **MAY 16 1930**
County of **Madison**
City of **Rehburg**

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. **100**
Primary Registration District No. **2178**
(No. _____ St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. **70303**
Local Registrar's No. **19**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **still born**
(Write the word)

6. DATE OF BIRTH

still born April 20 1930
(Month) (Day) (Year)

7. AGE

still born
IF LESS than 1 day how many
_____ hrs. or
Yrs. _____ Mos. _____ ds. _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Rehburg Idaho**

10. NAME OF FATHER

Mark H. Fitch

11. BIRTHPLACE OF FATHER

(State or Country) **Rehburg**

12. MAIDEN NAME OF MOTHER

Sarah L. Simpson

13. BIRTHPLACE OF MOTHER

(State or Country) **Utah**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mark H. Fitch**
(Address) **Rehburg Idaho**

15. Filed **4/20/1930** **X. J. McOmney**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **4/30 1930** to **April 20 1930**, that I last saw h.— alive on **still born** 19—, and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH was as follows:

still born
(Twins) 1 dead other alive.

Chronic nephritis
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

High blood pressure
Albumen in urine

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

April 20 1930 (Address) **H. B. Rigby, M. D. Rehburg, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rehburg Cemetery 4/20 1930

20. UNDERTAKER

ADDRESS

W. E. McOmney

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

24780

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

MAY 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH **S** 180876

County of Madison
City of Sugar

No. 213-18-033-349 St.

Registration District No. 100 State File No. 80

(If born in hospital or institution give name.)

Prim. Registration District No. 2178 Local Registrar's No. 80

FULL NAME OF CHILD Steebom

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimacy <u>yes</u>	Date of birth <u>4 18 1930</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 6 (a) Born alive and now living 4

Born alive but now dead 2 Steebom Stillborn

FATHER
FULL NAME Merced Baca
Residence (Usual place of abode) Sugar City

MOTHER
FULL MAIDEN NAME Quana Martiney
Residence (Usual place of abode) Sugar City

If non-resident, give place and State.

If non-resident, give place and State.

Color or race Brown Age at last Birthday 53 (Years)

Color or race Brown Age at last Birthday 35 (Years)

Birthplace Mexico (City and State or County)

Birthplace Mexico (City and State or County)

Occupation Farmer

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 8:30 P M. on the date above stated.

(Signature) Louie A. Reah

(Physician or midwife)

Address Reeburg, Idaho

Filed 5/15 1930 W. H. Jones Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
455 FIFTH AVENUE
NEW YORK 17, N. Y.

There is no other evidence in the letter which
indicates in any way that either person was
or should have been in the room. A telephone
call was made to the latter person shortly
after the time when the letter was received.

20-56-1930-18(50) D-117

(continued on next page)

1. I hereby certify that I have read the plain of this bill, and that

DECLASSIFIED BY AT-00000000000000000000000000000000

[illegible]

.....

Productive United States of America

1. NAME
 2. DATE
 3. TIME
 4. PLACE
 5. REMARKS

10-11-68

It is hoped that this will be a first step in the process of bringing the community back to its former glory.

[illegible]

SECRET

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific information required.

12

CONFIDENTIAL

SUBJECT: STATE DEPT. FILE NO. 100-107000-100000

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19

1. ~~RECEIVED~~ MAY 16 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSCounty of MadisonRegistration District No. 100City of RehburgPrimary Registration District No. 2178

(No. _____ St.)

State File No. 76302Local Registrar's No. 18

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Becca

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMaleMexicanInfant
(Write the word)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

IF LESS than 1
day how many
hrs. or
min.?Still Born
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Superior, Idaho

10. NAME OF

Father

Mercede Becca

11. BIRTHPLACE

OF FATHER

(State or Country)

Mexico

12. MAIDEN NAME

OF MOTHER

Juanita Martinez

13. BIRTHPLACE

OF MOTHER

(State or Country)

Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

McCluskey

(Address)

Rehburg, Idaho

15.

Filed

4/201930W. J. McNamee
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 19
Still Born
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 18 1930 to April 18 1930that I last saw h. at home 1930and that death occurred on the date stated above, at M

The CAUSE OF DEATH* was as follows:

Unknown
macerated fetus
(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

4/19 1930

(Address)

Rehburg, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rehburg Cemetery1930

20. UNDERTAKER

ADDRESS

Becker

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH ED MAY 16 1930

County of Madison
City of Reynoldsburg
No. 253-211033-866 St. 1

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH **S**180877

Registration District No. 100 State File No. 2178
Local Registrar's No. 29
(If born in hospital or institution give name.) Prim. Registration District No. 2178

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> }</u> and <u> }</u> Number in order of birth <u>1</u>	Legitimate? <u>Y</u>	Date of birth <u>April 11, 1930</u> (Month) (Day) (Year)
----------------------------	--	----------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 4 (a) Born alive and now living 1
Born alive but now dead 1 Stillborn 3

FATHER FULL NAME <u>Orville Milton Bell</u> Residence (Usual place of abode) <u>Reynoldsburg</u> If non-resident, give place and State <u> </u> Color or race <u>W</u> Age at last Birthday <u>31</u> (Years) Birthplace <u>Reynoldsburg, Mo.</u> (City and State or County) Occupation <u>Auto Mechanic</u>	MOTHER FULL MAIDEN NAME <u>Deloris Emma Huff</u> Residence (Usual place of abode) <u>Reynoldsburg</u> If non-resident, give place and State <u> </u> Color or race <u>W</u> Age at last Birthday <u>29</u> (Years) Birthplace <u>St. Louis, Mo.</u> (City and State or County) Occupation <u>Housewife</u>
--	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 10:45 P M. on the date above stated.

(Signature) H. B. Rigby
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address
Filed 7/5 19 30 Reynoldsburg
Registrar.

RECEIVED JUN 9 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT
MAY 27 1930

Boise, Idaho

180877

Mrs. O.M. Bell
Rexburg

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD Baby
PLACE OF BIRTH Rexburg DATE OF BIRTH April 11, 1930 SEX OF CHILD Female

1. Number of children born to this mother, including present birth 4
2. Number born alive and now living One
3. Born alive but now dead one
4. Number of children stillborn two

(Please write plainly)

Information with reference to
FATHER

Orville Milton Bell
(Full name)
373 / N. 4 W.
(Residence)

Age at last birthday 31
Rexburg, Ida.
(Birthplace)
auto Mechanic
(Occupation)

Information with reference to
MOTHER

Deloris Anna Bell
(Full maiden name)
373 / N. 4 W.
(Residence)

Age at last birthday 28
Teton, Idaho
(Birthplace)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C. K. Macey
C.K. Macey
Special Agent, Bureau of the Census.



RECEIVED MAY 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH.

DO NOT WRITE IN THIS SPACE

State File No. 70301

PLACE OF DEATH

County of MadisonCity of RephungRegistration District No. 100Primary Registration District No. 2178Local Registrar's No. 17

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dale Bell(a) Residence. No. Rephung St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX

Male

4. COLOR OR RACE

White

5. Single, Married, Widowed, or Divorced (write the word)

Married

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

Still Born

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Rephung
(State or country)

10. NAME OF FATHER

Oval Bell11. BIRTHPLACE OF FATHER (city or town)
(State or Country)Rephung Idaho

12. MAIDEN NAME OF MOTHER

Deloris Huff13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)Teton Idaho

14.

Informant Oval Bell
(Address) Rephung Idaho

15.

Filed 7/12, 1930Registrar J. W. Young

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Born Dead April 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 11, 1930, to April 11, 1930that I last saw him alive on April 11, 1930and that death occurred, on the date stated above, at not known

The CAUSE OF DEATH* was as follows:

(Stillborn)
(Hydrocephalus)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis

(Signed) H. B. Taylor, M. D.April 12, 1930 (Address) Rephung

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Teton Cemetery Apr 12 1930

20. Undertaker

Address

W. B. Eckert Rephung

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

269-112-201-394
PLACE OF BIRTH JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Ada
City of Boise
No. _____ St. _____ Registration District No. 2 File No. _____
Hospital St. Luke's Primary Registration District No. 1004 Registered No. 246
FULL NAME OF CHILD Donald DeVere Korup

(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other? <u>X</u> } and { Number in order of birth <u>X</u>	Legitimate? <u>yes</u>	Date of birth <u>May 12</u> 19 <u>30</u> (Month) (Day) (Year)
-----------------------	---	------------------------	--

(To be answered only in event of plural births)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth... 3 ... Number of child of this mother now living, including present birth... 2 ...

FATHER		MOTHER	
FULL NAME	<u>Fred D. Korup</u>	FULL MAIDEN NAME	<u>Audrey L. Liddle</u>
RESIDENCE	<u>Boise</u>	RESIDENCE	<u>Boise</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>26</u> (Years)	AGE AT LAST BIRTHDAY	<u>23</u> (Years)
BIRTHPLACE	<u>Idaho</u>	BIRTHPLACE	<u>Utah</u>
OCCUPATION	<u>Butcher</u>	OCCUPATION	<u>House-wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 5.30 P.M. on the date above stated.
(Born alive or stillborn)

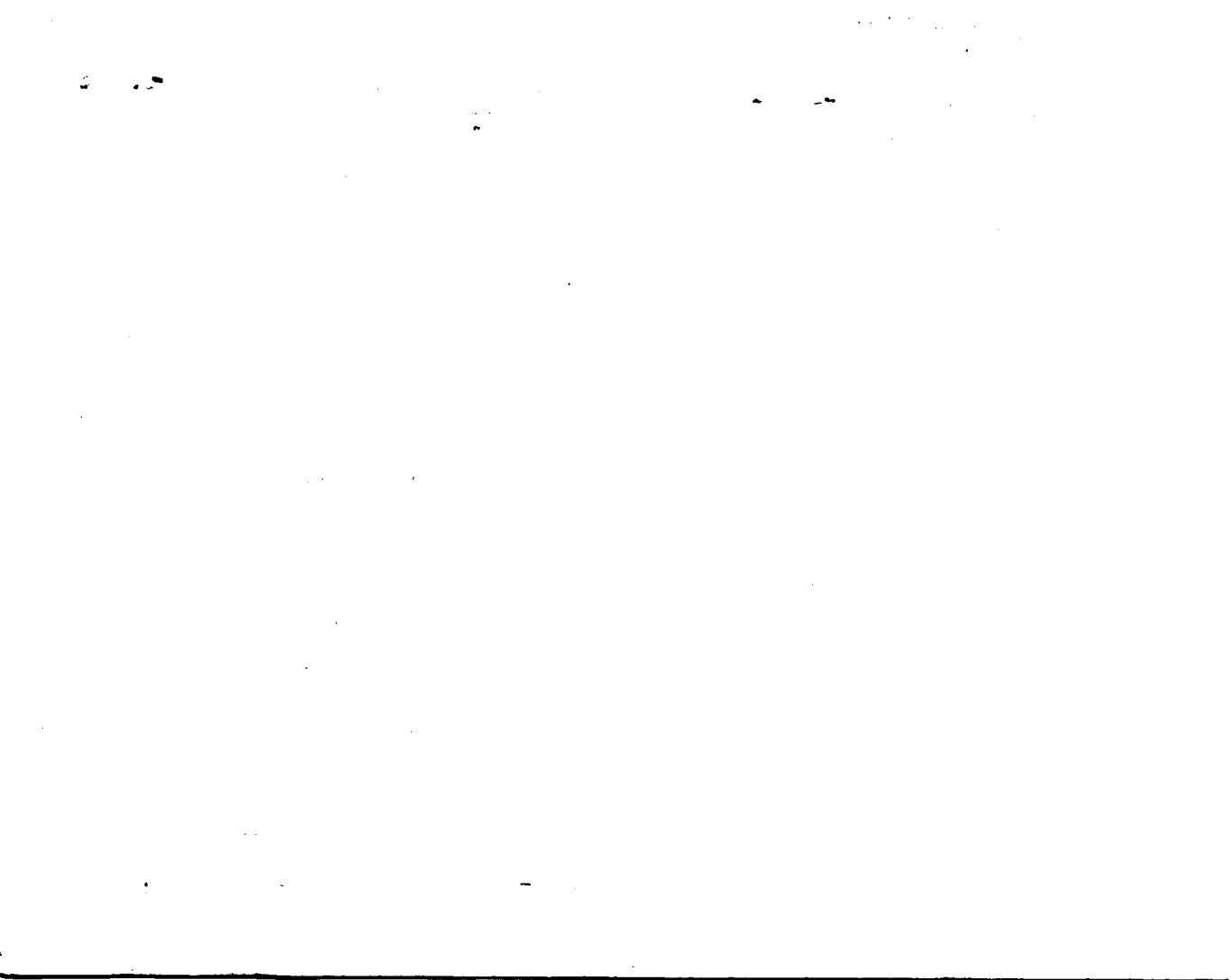
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Edward J. Binner M.D.
Physician
(Physician or midwife)

Give names added from a supplemental report.
_____, 19_____

Registrar.

Address 202-203 Robert Noble Bldg. Boise
Filed 5-16-30 1930 W.H. Rhodes
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 10372

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2Primary Registration District No. 1004Local Registrar's No. 140(No. St. Luke's Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Donald De Lee Group(a) Residence. No. 2410 Woodlawn Ave.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 6/12/30

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer none

9. BIRTHPLACE (city or town) (State or country) Boise

10. NAME OF FATHER Paul Group

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kearney, Ida

12. MAIDEN NAME OF MOTHER Audrey Liddle

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Salt Lake City

14. Informant Paul Group
(Address) Boise

15. Filed 5-15-30 W.H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 12 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY that I attended deceased from May 12, 1930, to May 12, 1930
that I last saw him alive on May 12, 1930
and that death occurred, on the date stated above, at 12:30 m.
The CAUSE OF DEATH* was as follows:

Still born
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Donald De Lee Group, M. D.

May 12, 1930 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery Date of Burial 5/12 1930

20. Undertaker Schreiber & W. Baum Address Boise

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH JUN 9 1930
County of Bingham
City of Shelley
No. 465-28-006-713 St.

(If born in hospital or institution
give name.)

FULL NAME OF CHILD

Registration District No. 121 State File No. S181067
Prim. Registration District No. 2194 Local Registrar's No. 165
Stillbirth Manson
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u>	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>May 13</u> — <u>1930</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth. 1 (a) Born alive and now living. 0

Born alive but now dead. Stillborn 1

FATHER
FULL NAME Walter A. Manson
Residence (Usual place of abode) Shelley Idaho
If non-resident, give place and State
Color or race White Age at last Birthday 38 (Years)
Birthplace (City and State or County)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Pack
Residence (Usual place of abode) Shelley Ida.
If non-resident, give place and State
Color or race White Age at last Birthday 38 (Years)
Birthplace (City and State or County)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at Shelley M.
on the date above stated.

(Signature)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address

Filed June 6 1930 Shelley Ida. Registrar.

STATE OF NEW YORK
JULY 1914

Wherefore, the undersigned
do hereby certify that the
child is and has been
born alive and well.

on the date above stated.

(Signature)

I, the undersigned, hereby certify that the child who was born

(NAME OF ATTENDING PHYSICIAN OR MIDWIFE)

(Occupation)

(City and State or County)

(Date of Birth)

It is to be noted that the child was born

(Place of Birth)

(Name)

(Mother)

(to) Born alive and well living

(Name of Child)

(Date of Birth)

(Sex)

(Weight)

(Is the child the same as the child who was born

(Place of Birth)

(Registration Number)

(Certificate of Birth)

STATE OF NEW YORK
JULY 1914

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instruction on back of certificate.

RECEIVED JUN 9 1930		STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS		DO NOT WRITE IN THIS SPACE State File No. 24418 Local Registrar's No. 63	
PLACE OF DEATH County of <u>Bingham</u> City of <u>Shelley Ida</u>		CERTIFICATE OF DEATH Registration District No. <u>121</u> Primary Registration District No. <u>2144</u>			
(No. _____) (If death occurred in a hospital or institution, give its name instead of street and number.)					
2. FULL NAME <u>Florence Monson</u>					
(a) Residence. No. _____ St. _____ (Usual place of abode) Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)					
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Infant</u>			
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____					
6. DATE OF BIRTH (month, day and year) <u>May 13 1930</u>					
7. AGE <u>Still Born</u>	Years	Months	Days	If LESS than 1 day, hrs. or min.	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer					
9. BIRTHPLACE (city or town) (State or country) <u>Shelley Idaho</u>					
10. NAME OF FATHER <u>Nels H. Monson</u>					
11. BIRTHPLACE OF FATHER (city or town) (State or Country) <u>Rexburg Ida</u>					
12. MAIDEN NAME OF MOTHER <u>Florence Pack</u>					
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) <u>Richmond Utah</u>					
14. Informant <u>Nels H. Monson</u> (Address) <u>Shelley Route-2</u>					
15. Filled <u>May 12 1930</u> <u>Wm. M. Allen E. Patrio</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16. DATE OF DEATH <u>May 13 1930</u> (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from <u>May 13 1930</u> to <u>May 13 1930</u> that I last saw <u>or born dead May 13 1930</u> and that death occurred, on the date stated above, at <u>8:12 P.M.</u> The CAUSE OF DEATH* was as follows: <u>Exencephalus</u> (duration) yrs. mos. ds. CONTRIBUTORY <u>None</u> (Secondary) (duration) yrs. mos. ds.					
18. Where was disease contracted if not at place of death? <u>Yes</u> Did an operation precede death? <u>No</u> Date of _____ Was there an autopsy? <u>No</u> What test confirmed diagnosis? <u>7 M. O. P. K. S. M. D.</u> (Signed) <u>May 14 1930</u> (Address) <u>Shelley Ida</u>					
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
19. Place of Burial, Cremation, or Removal <u>Goodwin Cemetery</u> Date of Burial <u>May 14 1930</u>					
20. Undertaker <u>None</u> Address <u>5-15-30</u>					

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED JUN 9 1930 STATE OF IDAHO
County of Bingham DEPARTMENT OF PUBLIC WELFARE
City of Blackfoot BUREAU OF VITAL STATISTICS
No. St. CERTIFICATE OF BIRTH **S 181097**
892 102 006 238 Registration District No. 121 State File No.
(If born in hospital or institution
give name.) Prim. Registration District No. 1007 Local Registrar's No. 138
FULL NAME OF CHILD Unnamed Robert

(If stillborn, substitute the word "Stillborn" for name of child)

Sex of Child <u>male</u>	<input checked="" type="checkbox"/> Twin <input type="checkbox"/> Triplet or other? (To be answered only in event of plural births)	and <input type="checkbox"/>	Number in order of birth	Legitimate <u>yes</u>	Date of birth <u>May 2 1930</u> (Month) (Day) (Year)
--------------------------	--	------------------------------	--------------------------	-----------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 4 (a) Born alive and now living 3
Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME <u>Gerald Clyde Tibbels</u>	FULL MAIDEN NAME <u>Mary Alice Schiess</u>
Residence (Usual place of abode) <u>Blackfoot Ida</u>	Residence (Usual place of abode) <u>Blackfoot Ida</u>
If nonresident, give place and State	If nonresident, give place and State
Color or race <u>White</u> Age at last Birthday	Color or race <u>White</u> Age at last Birthday
Birthplace <u>Utah</u> (Years)	Birthplace <u>Utah</u> (Years)
(City and State or Country)	(City and State or Country)
Occupation <u>Laborer</u>	Occupation <u>Housewife</u>

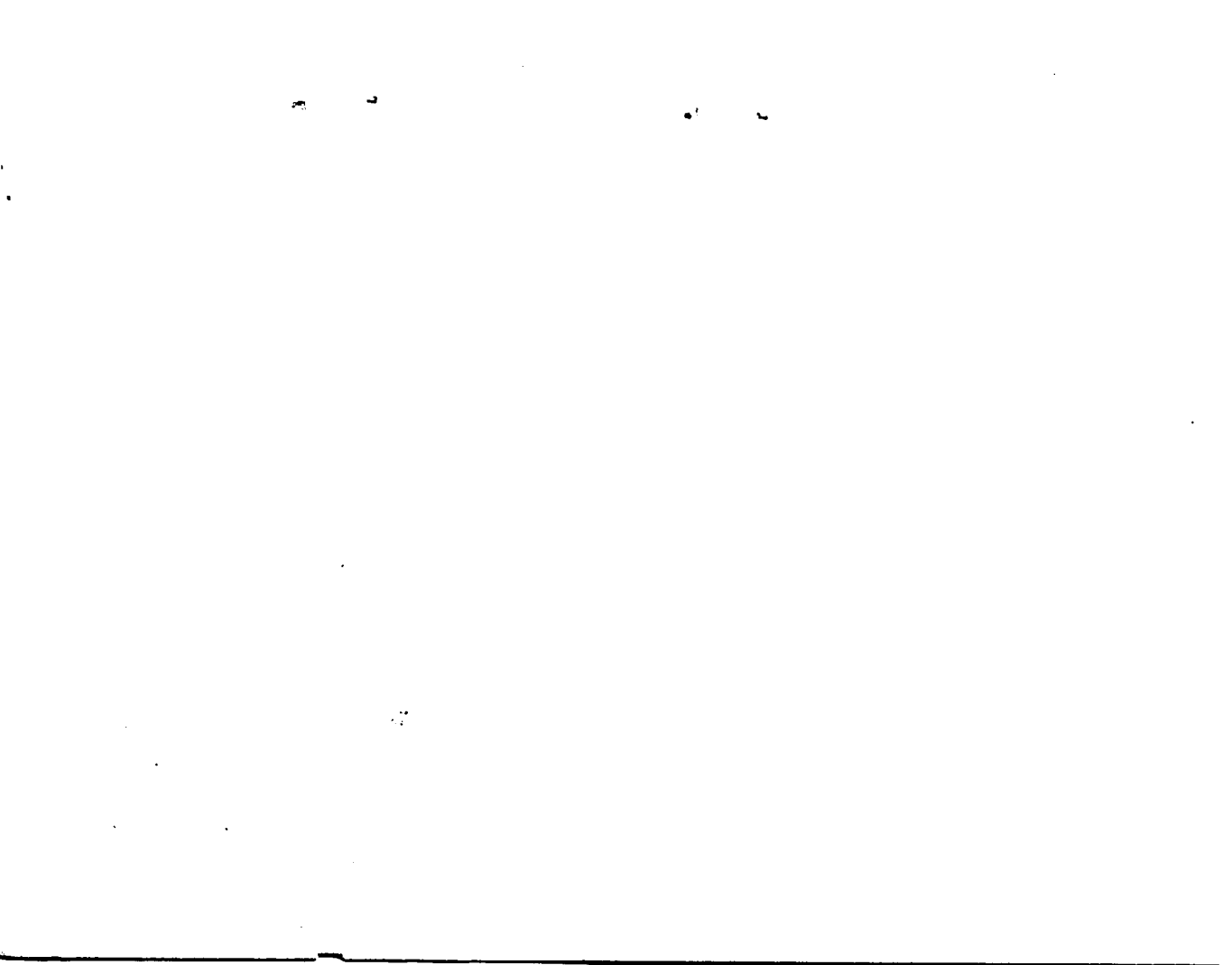
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive { Stillborn } at 4:50 p. M.
on the date above stated.

(Signature) W W Beck

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Blackfoot, Idaho
Filed June 2 1930 W W Beck Registrar.



RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 20422

PLACE OF DEATH
County of Bingham
City of Blackfoot, Ida

Registration District No. 131
Primary Registration District No. 1007

Local Registrar's No. 58

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn Hibbert

(a) Residence. No. _____ St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6. DATE OF BIRTH (month, day and year) May 7, 1930

7. AGE Stillborn Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Blackfoot, Ida
(State or country)10. NAME OF FATHER Gerald Clyde Hibbert11. BIRTHPLACE OF FATHER (city or town) Utah
(State or Country)12. MAIDEN NAME OF MOTHER Mary Alice Schiess13. BIRTHPLACE OF MOTHER (city or town) Utah
(State or Country)14. Informant Gerald Hibbert
(Address) Blackfoot15. May 7 - 1930 Mr. Walter Schiess Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Stillborn May 7 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Stillborn, 19____, to May 7, 1930.
that I last saw h. _____ alive on _____, 19____.
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Thrombosis of
Cord
Had been dead several days
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death? _____Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) W. Beck M. D.
5/3, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Blackfoot City Burial Date of Burial 5-3-30

20. Undertaker Modern Mortuary Address Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

181097-4

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

181104

County of Bingham
City of Shelley

No. 154-104006-253 St.

(If born in hospital or institution give name.)

Registration District No. 121 State File No.

Prim. Registration District No. 2194 Local Registrar's No. 131

FULL NAME OF CHILD Stillborn Anderson

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>May 4</u> 19 <u>30</u> (Month) (Day) (Year)
--------------------------	-----------------------------------	-----------------------------------	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? 10% Argrol

Number of child of this mother, including present birth 2 (a) Born alive and now living

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME GEO. R. Anderson
Residence (Usual place of abode) Shelley, Idaho
If nonresident, give place and State
Color or race white Age at last Birthday 26 (Years)
Birthplace Salem, Idaho (City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Pearl Kelley
Residence (Usual place of abode) Shelley, Idaho
If nonresident, give place and State
Color or race white Age at last Birthday 25 (Years)
Birthplace Shelley, Idaho (City and State or Country)
Occupation Housekeeper

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 8:15 A. M. on the date above stated.

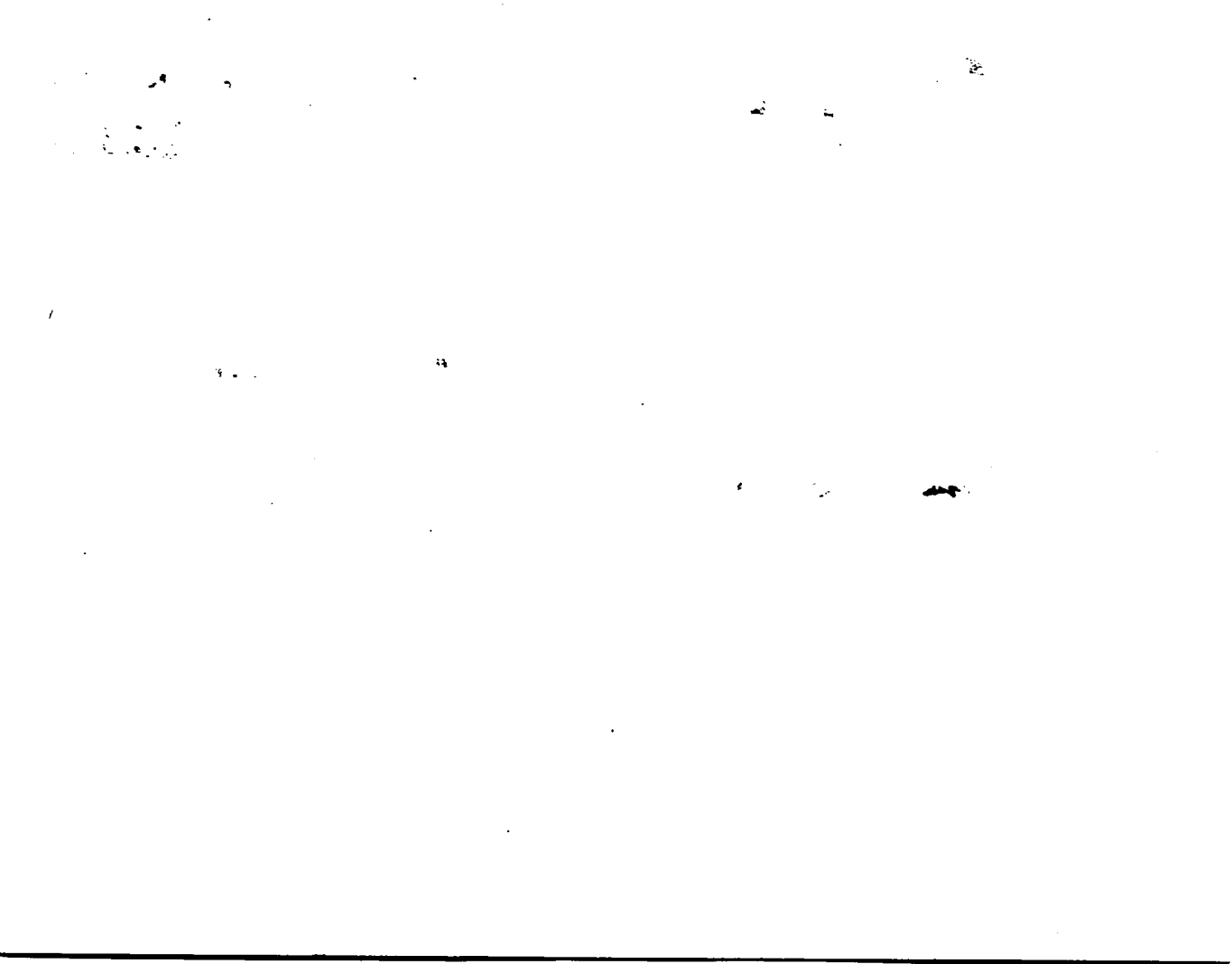
(Signature) Edwin Cutler M.D.

(Physician or midwife)

Address Shelley, Idaho

Filed June 1 1930 Edwin Cutler M.D. Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



181104 +

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH JUN 9 1930

Registration District No. 121

County of Brigham

Primary Registration District No. 2142

File No. 619

City of Shelley, Ida.

(No. St.)

Registered No. 619

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Single (Write the word.)

6. DATE OF BIRTH

5 - 4 - 1930
(Month) (Day) (Year)

7. AGE

still born IF LESS than 1 day
how many hrs.
Yrs. Mos. ds. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Shelley Idaho.

10. NAME OF FATHER

Geo. R. Anderson.

11. BIRTHPLACE OF FATHER

(State or Country)

Salem Idaho.

12. MAIDEN NAME OF MOTHER

Pearl Keiley

13. BIRTHPLACE OF MOTHER

(State or Country)

Shelley Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

G. R. Anderson
Shelley Ida.

15.

Filed

1930 M. K. E. Petrie
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5 - 4 - 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5 - 4 - 1930 to 5 - 4 - 1930

that I last saw him alive on 1930

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still birth of several weeks standing

(Duration) Yrs. mos. ds.

Contributory (Secondary)

See other side

(Duration) yrs. mos. ds.

(Signed)

Edwin Carter M. D.

5-4-1930

(Address) Shelley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

at home

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shelley Cemetery

5-4-1930

20. UNDERTAKER

ADDRESS

none

The period of gestation was about 6½ or 7 months. (Though the child had been dead probably 2 or 3 weeks.

The cause is at present unknown while the mother was not in perfect health. There was no evidence of nephritis at birth. Though no warfarin has yet been made, it is possible that the mother was operated on ovaries and all of the blood was removed. A small piece of ovary size of a pea was removed.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH
RECEIVED MAY 24 1930
County of Bonneville
City of Idaho Falls, Idaho
No. 219203010-556 St. L.D.S. Hospital

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S181158

Registration District No. 73 State File No. 121
Prim. Registration District No. 2120 Local Registrar's No. 121
FULL NAME OF CHILD "Stillbirth" Barnes
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>Apr. 3</u> 19 <u>30</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What prophylactic was used to prevent Ophthalmia Neonatorum? Neosporin

Number of child of this mother, including present birth 5 (a) Born alive and now living 3
Born alive but now dead 0 Stillborn 2

FATHER		MOTHER	
FULL NAME <u>Wm. James Barnes</u>	FULL MAIDEN NAME <u>Thora Newman</u>	FULL NAME <u>Wm. James Barnes</u>	FULL MAIDEN NAME <u>Thora Newman</u>
Residence (Usual place of abode) <u>Milo</u>	Residence (Usual place of abode) <u>Milo</u>	Residence (Usual place of abode) <u>Milo</u>	Residence (Usual place of abode) <u>Milo</u>
If non-resident, give place and State <u> </u>	If non-resident, give place and State <u> </u>	If non-resident, give place and State <u> </u>	If non-resident, give place and State <u> </u>
Color or race <u>White</u> Age at last Birthday <u>32</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>27</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>32</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>27</u> (Years)
Birthplace <u>Idaho Falls, Idaho</u> (City and State or County)	Birthplace <u>Housewife</u> (City and State or County)	Birthplace <u>Idaho Falls, Idaho</u> (City and State or County)	Birthplace <u>Housewife</u> (City and State or County)
Occupation <u>Farmer</u>	Occupation <u>Housewife</u>	Occupation <u>Farmer</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 1:18 P.M. on the date above stated. Cesarian

(Signature) [Signature]
Physician
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Idaho Falls, Idaho
Filed Apr 24 1930 [Signature] Registrar.

THESE ARE THE NAMES OF THE MEN WHO WERE
KILLED IN THE BOMBING OF THE LINCOLN
MEMORIAL IN WASHINGTON, D. C. ON APRIL 4, 1968.
THEY WERE ALL STUDENTS OF THE
AMERICAN UNIVERSITY IN WASHINGTON, D. C.
AND WERE ALL MEMBERS OF THE
NATIONAL ASSOCIATION FOR THE
ADVANCEMENT OF COLORED PEOPLE (NAACP).

There seems to be little doubt that the United States is the only country in the world which has a large and powerful navy. The United States Navy is the largest and most powerful navy in the world. It is the only navy which has the ability to project power globally. The United States Navy is the only navy which has the ability to project power globally. The United States Navy is the only navy which has the ability to project power globally.

(b)(7)(D), (b)(7)(F)

US TO 1-10-1941
(67)w hlm to n hlm 1941

CONFIDENTIALITY OF ATTENDING PHYSICIAN ON REQUEST

Overleaf

CONFIDENTIAL

100-443887-100

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

1100112

1/2 cup (125 ml) of water

CONFIDENTIAL

Field Hospital, 1st Airborne Div., 1st Airborne Div., 1st Airborne Div.

CONFIDENTIAL

... ..

100-443887-100

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 10175

PLACE OF DEATH

County of Bonneville
City of Idaho Falls, Idaho

Registration District No. 73
Primary Registration District No. 2177

Local Registrar's No. 67

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn

(a) Residence. No. _____ St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 3, 1930

7. AGE Years Months Days If LESS than 1 day,
Stillborn --- --- --- hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls, Idaho
(State or country) L.D.S. Hospital

10. NAME OF FATHER
William James Barnes

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Idaho Falls, Idaho

12. MAIDEN NAME OF MOTHER
Thora Newman

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Milo, Idaho

14. Informant Mrs. William James Barnes
(Address) Rigby R#2

15. Filed Apr 19, 1930 Certified
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 3, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
April 3, 1930, to April 3, 1930
that I last saw her dead April 3, 1930

and that death occurred, on the date stated above, at 2:00P. m.

The CAUSE OF DEATH* was as follows:

Asphyxiation due to premature separation of placenta in utero

(duration) yrs. mos. ds.

CONTRIBUTORY Premature 8 Months utero
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death? Rigby R#2

Did an operation precede death? No Date of

Was there an autopsy? Cesarian Section

What test confirmed diagnosis? Gen. Mother.

(Signed) [Signature], M. D.
April 4, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Cremation at L.D.S. Apr 3 1930

20. Undertaker Hospital Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

181158 +

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACED IN FILE MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 181168

County of Bonneville
City of Idaho Falls
No. 355-225-010843 St.

L. S. S. Hospital

(If born in hospital or institution
give name.)

Registration District No. 73 State File No. 167

Prim. Registration District No. 2172 Local Registrar's No. 167

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? Yes	Date of birth <u>Apr</u> <u>25</u> <u>1930</u> (Month) (Day) (Year)
-------------------------------	---	---	----------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Wilford D. Lee

Residence (Usual place of abode) Iona, Idaho

If nonresident, give place and State.

Color or race White Age at last Birthday 31
(Years)

Birthplace Iona, Idaho
(City and State or Country)

Occupation School Teacher

MOTHER
FULL MAIDEN NAME Lorene Hutchinson

Residence (Usual place of abode) Iona, Idaho

If nonresident, give place and State.

Color or race White Age at last Birthday 25
(Years)

Birthplace Winnipeg
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 12-07 P. M.
on the date above stated.

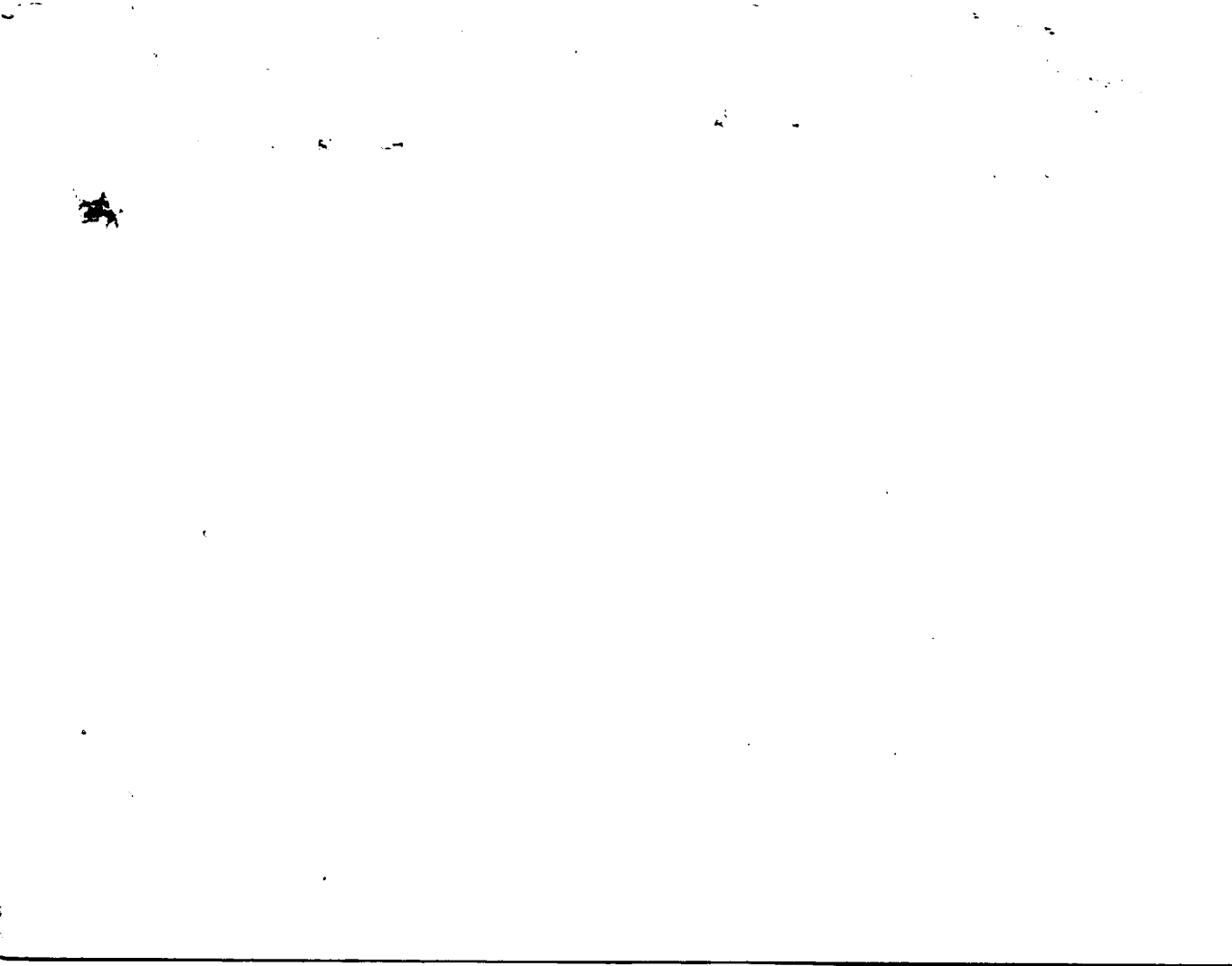
(Signature)

Physician
(Physician or midwife)

Address Idaho Falls, Idaho

Filed Apr 24 19 30 Registrar

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 10430

PLACE OF DEATH

County of BonanzaCity of Idaho FallsRegistration District No. 73Primary Registration District No. 211-0Local Registrar's No. 74

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Still born(a) Residence. No. Idaho Falls St.

(Usual place of abode)

Length of residence in city or town where death occurred.

yrs.

mos.

da.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. Single, Married, Widowed, or Divorced (write the word)

Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

still birth

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

12. MARRIED NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14.

Informant

(Address)

15.

Filed

April 25, 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 25 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 25, 1930, to April 25, 1930that I last saw him at his home April 25, 1930and that death occurred, on the date stated above, at 12:30 m.

The CAUSE OF DEATH* was as follows:

Immature growth of Placenta.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Examination(Signed) [Signature], M. D.725, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

CremationApr. 21 1930

20. Undertaker

Address

none

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH MAY 24 1930

County of Bonneville

City of Idaho Falls

No. 355-105010-391 St.

L. W. S. Hospital

(If born in hospital or institution
give name.)

FULL NAME OF CHILD

Registration District No. 73 State File No. S

Prim. Registration District No. 212-0 Local Registrar's No. 134

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other?	{ and } Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>April 5</u> <u>1930</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 12 (a) Born alive and now living 9

Born alive but now dead 2 Stillborn 1

FATHER FULL NAME <u>Oren Ward Lee</u>	MOTHER FULL MAIDEN NAME <u>Lydian Frances Tracy</u>
--	--

Residence (Usual place of abode) <u>Asgood Idaho</u>	Residence (Usual place of abode) <u>Asgood</u>
--	--

If non-resident, give place and State	If non-resident, give place and State
---------------------------------------	---------------------------------------

Color or race <u>white</u> Age at last Birthday <u>41</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>39</u> (Years)
---	---

Birthplace <u>Mills Idaho</u> (City and State or County)	Birthplace <u>Asgood Utah</u> (City and State or County)
--	--

Occupation <u>Farming</u>	Occupation <u>Housewife</u>
---------------------------	-----------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn Recessive at 4:25 A. M.
on the date above stated.

(Signature) [Signature]

(Physician or midwife)

Address Idaho Falls Idaho

Filed Apr 9 19 30 [Signature]

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

1. Name of child
 2. Date of birth
 3. Sex
 4. Race
 5. Religion
 6. Education
 7. Occupation
 8. Address
 9. City and State
 10. Country
 11. Date of registration
 12. Signature of parent
 13. Signature of registrar
 14. Seal of registrar

I hereby certify that I attended the birth of this child, who was born on the date above stated.

If there were no attending physician or midwife, then the father, mother, or other person present at the birth should make this statement.

This statement is required for the child to be registered.

I hereby certify that I attended the birth of this child, who was born on the date above stated.

If there were no attending physician or midwife, then the father, mother, or other person present at the birth should make this statement.

This statement is required for the child to be registered.

I hereby certify that I attended the birth of this child, who was born on the date above stated.

If there were no attending physician or midwife, then the father, mother, or other person present at the birth should make this statement.

This statement is required for the child to be registered.

I hereby certify that I attended the birth of this child, who was born on the date above stated.

If there were no attending physician or midwife, then the father, mother, or other person present at the birth should make this statement.

This statement is required for the child to be registered.

I hereby certify that I attended the birth of this child, who was born on the date above stated.

If there were no attending physician or midwife, then the father, mother, or other person present at the birth should make this statement.

This statement is required for the child to be registered.

I hereby certify that I attended the birth of this child, who was born on the date above stated.

If there were no attending physician or midwife, then the father, mother, or other person present at the birth should make this statement.

This statement is required for the child to be registered.

I hereby certify that I attended the birth of this child, who was born on the date above stated.

If there were no attending physician or midwife, then the father, mother, or other person present at the birth should make this statement.

This statement is required for the child to be registered.

I hereby certify that I attended the birth of this child, who was born on the date above stated.

If there were no attending physician or midwife, then the father, mother, or other person present at the birth should make this statement.

This statement is required for the child to be registered.

I hereby certify that I attended the birth of this child, who was born on the date above stated.

If there were no attending physician or midwife, then the father, mother, or other person present at the birth should make this statement.

This statement is required for the child to be registered.

I hereby certify that I attended the birth of this child, who was born on the date above stated.

If there were no attending physician or midwife, then the father, mother, or other person present at the birth should make this statement.

This statement is required for the child to be registered.

I hereby certify that I attended the birth of this child, who was born on the date above stated.

If there were no attending physician or midwife, then the father, mother, or other person present at the birth should make this statement.

This statement is required for the child to be registered.

I hereby certify that I attended the birth of this child, who was born on the date above stated.

If there were no attending physician or midwife, then the father, mother, or other person present at the birth should make this statement.

This statement is required for the child to be registered.

I hereby certify that I attended the birth of this child, who was born on the date above stated.

If there were no attending physician or midwife, then the father, mother, or other person present at the birth should make this statement.

This statement is required for the child to be registered.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 20433

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
(No. L.H.S. Hospital)

Local Registrar's No. 60

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 5, 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls Idaho
(State or country)

10. NAME OF FATHER Oren Ward Lee

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Lynia Frances Tracy

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Agden Utah

14. Informant Oren Ward Lee
(Address) Idaho Falls R 257

15. Apr 5, 1930 E. J. Jensen
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 5, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw him alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Premature birth 7 Mos

CONTRIBUTORY (Secondary) La Certe Premature birth
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? _____
Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? Chloroform
(Signed) _____, M. D.
, 19____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls Date of Burial Apr 6/30 19____

20. Undertaker Idaho Falls Address _____

181187+

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH Canyon JUN 11 1930
County of Caldwell
City of Caldwell

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 181209

No. 419-220-4231 St.
Caldwell Sanitarium

Registration District No. 3 State File No. 181209

(If born in hospital or institution
give name.)

Prim. Registration District No. 2005 Local Registrar's No. 88

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Girl	Twin Triplet or other?		and	Number in order of birth	Legitimate?	Yes	Date of birth	5/12/30	19
		(To be answered only in event of plural births)						(Month)	(Day)	(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 1

Born alive but now dead _____ Stillborn _____

FATHER
FULL NAME F. E. Marchek

Residence (Usual place of abode) Harper, Oregon

If nonresident, give place and State White

Color or race _____ Age at last Birthday 25 (Years)

Birthplace Wyoming
(City and State or Country)

Occupation Painting

MOTHER
FULL MAIDEN NAME Beatrice Stagg

Residence (Usual place of abode) Harper, Oregon

If nonresident, give place and State White

Color or race _____ Age at last Birthday 22 (Years)

Birthplace Utah
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

11:45 P

I hereby certify that I attended the birth of this child, who was Stillborn at _____ M.
on the date above stated.

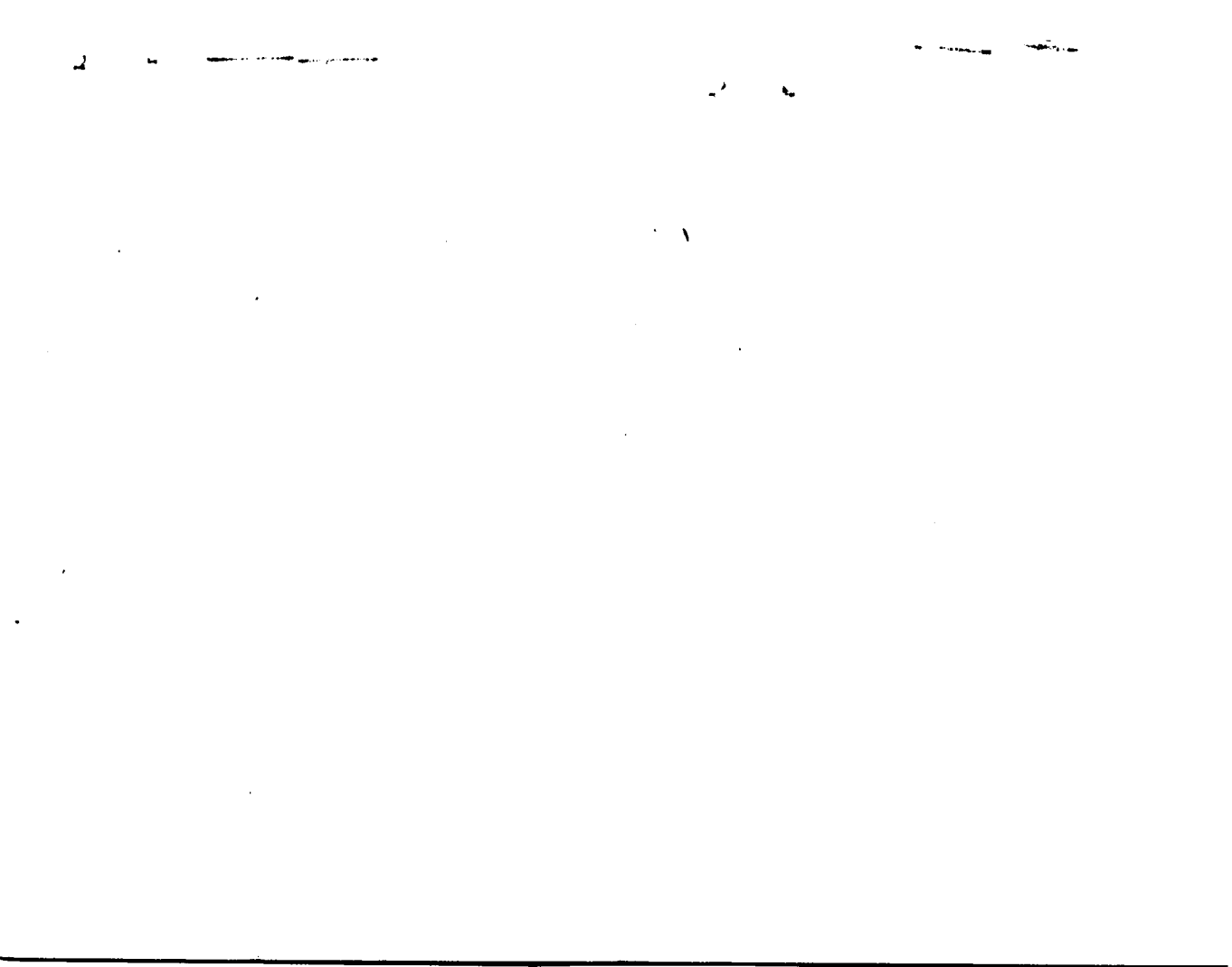
(Signature) F. M. Cole
M. D.

(Physician or midwife)
Caldwell, Idaho

Address _____

Filed 5-19-30 John D. Meyer
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

PHYSICIAN

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSRECEIVED JUN 11 1930
PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 0513

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 2005

Local Registrar's No. 52

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Marchek

(a) Residence. No.

St.

(Usual place of abode.)

(If nonresident give city or town and State.)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE White	5. Single, Married, Widowed, or Divorced (write the word.)
------------------	---------------------------	---

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
0		0	0	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Caldwell
(State or country) Idaho

10. NAME OF FATHER Frank Marchek

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Wyoming

12. MAIDEN NAME OF MOTHER Beatrice Stagg

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Utah14. Informant Frank Marchek
(Address) Harper Oregon15. Filed 5-13-1930 John H. Meyer
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 12, 1930

(Month)

(Day)

19. (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 12, 1930, to May 13, 1930,
that I last saw him on May 13, 1930.

and that death occurred, on the date stated above, at _____ m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Unknown

Spilleon
(duration) _____ yrs. _____ mos. _____ ds.CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) J. H. Meyer, M. D.
5-13-1930 (Address) Caldwell

19. Place of Burial, Cremation, or Removal

Date of Burial

Canyon Hill

5-13-30 19

20. Undertaker

Address

Paul L. Case

Caldwell, Id

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples; (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of** (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia, "PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

296 209 014 982

PLACE OF BIRTH

RECEIVED JUN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH **181250**

County of Canyon

City of Nampa

No. _____ St. _____

Registration District No. 7

File No. _____

Hospital _____

Primary Registration District No. 1006

Registered No. 108

FULL NAME OF CHILD

Archie Laver Brownfield

(Certificate of no value without full name of child.)

Sex of Child Female

Twin
Triplet
or other?

{ and }

Number
in order
of birth

Legiti-
mate?

Yes

Date of
birth

May 9

1923

(To be answered only in event of plural births)

(Month)

(Day)

(Year)

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth ONE

Number of child of this mother now living, including present birth NONE

FULL
NAME

FATHER

Earl Edward Brownfield

FULL
MAIDEN
NAME

MOTHER

Cara May Roby

RESIDENCE

Nampa

RESIDENCE

Gregg Nampa

COLOR

White

AGE AT LAST
BIRTHDAY

27
(Years)

COLOR

White

AGE AT LAST
BIRTHDAY

28
(Years)

BIRTHPLACE

Illinois

BIRTHPLACE

Oregon

OCCUPATION

Laborer

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____
on the date above stated.

Still born, 8:00 P

M.

(Born alive or stillborn)

{ *When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth. }

(Signature)

C.R. Meredith Jr.

(Physician or midwife)

Give names added from a supplemental report.

_____, 19____

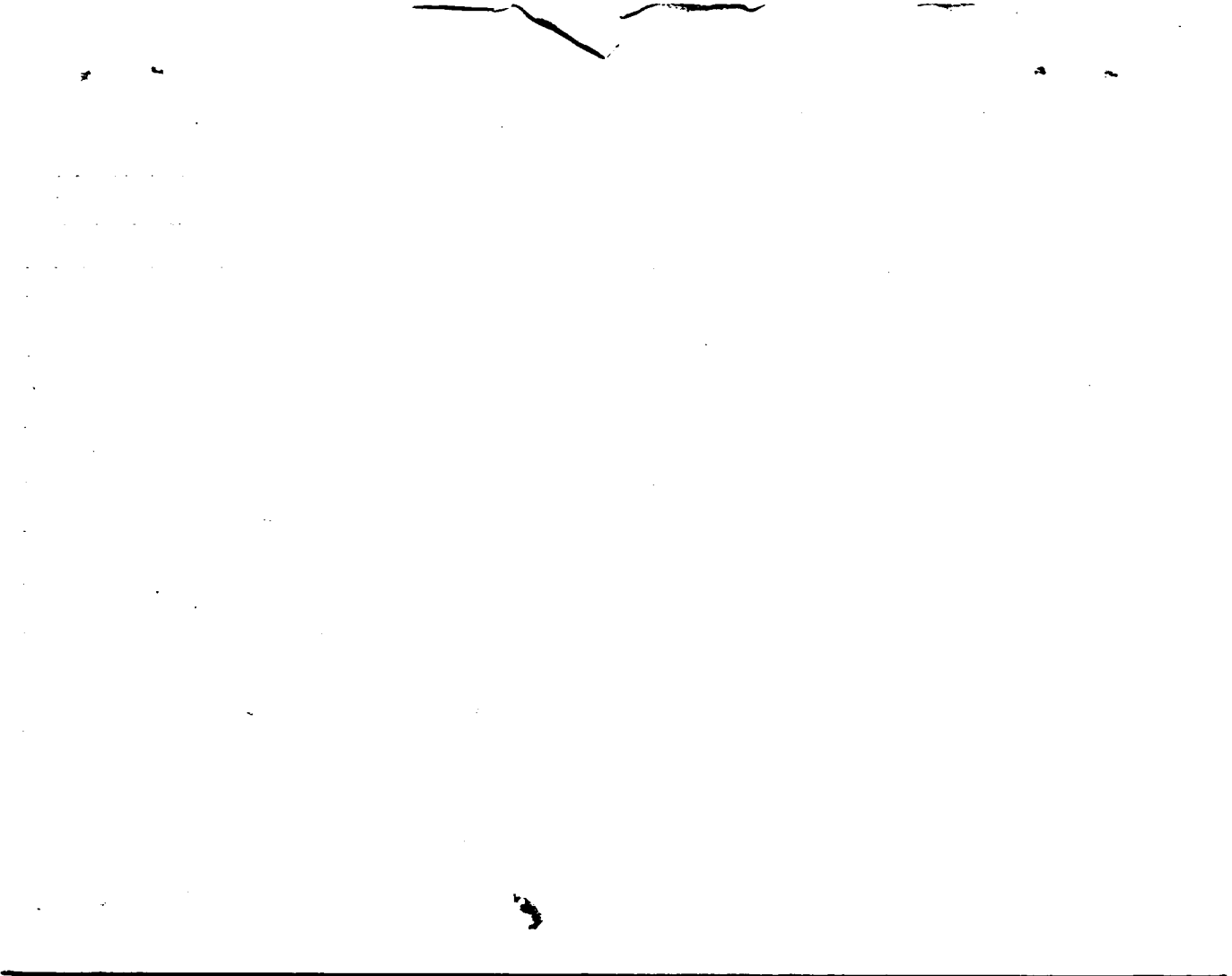
Registrar.

Address

Filed

5-1 30 Death County

Registrar.



RECEIVED JUN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **70500**

PLACE OF DEATH

County of CanyonCity of NampaRegistration District No. 7Primary Registration District No. 7006Local Registrar's No. 58

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Inf, daughter of Mr and Mrs, Earl Brownfield(a) Residence. No. 1605-3 st. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Fem.

4. COLOR OR RACE

White5. Single, Married, Widowed,
or Divorced (write the word)5a. If married, widowed, or divorced Daughter of
HUSBAND of Mr. and Mrs. Brownfield
(or) WIFE of6. DATE OF BIRTH (month, day and year) May 9, 19307. AGE Years Months Days If LESS than 1 day,
hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work. None(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Nampa Ida.
(State or country)10. NAME OF FATHER Earl Brownfield11. BIRTHPLACE OF FATHER (city or town) Ill.
(State or Country)12. MAIDEN NAME OF MOTHER Cora M. Roby13. BIRTHPLACE OF MOTHER (city or town) Ore.
(State or Country)14. Informant Earl Brownfield
(Address) 1605 3st No.15. File 5-10, 1930 Earl Brownfield
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 9, 1930

(Month) (Day) (Year)

17. I HEREBY CERTIFY, that I attended deceased from

at birth 1930
that I last saw h. May 9 1930
alive on May 9 1930
and that death occurred, on the date stated above, at 30 m.

The CAUSE OF DEATH* was as follows

CONTRIBUTORY
(Secondary)18. Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. M. Meredith D.C. M. D.May 10, 1930 (Address)*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Kohlerlawn

19

20. Undertaker

F. K. Robinson

Address

Nampa Ida.

m

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

1872507

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED JUN 5 1930 STATE OF IDAHO
County of Lemhi DEPARTMENT OF PUBLIC WELFARE
City of Winchester BUREAU OF VITAL STATISTICS
No. _____ St. _____ CERTIFICATE OF BIRTH
712 219 031 '652 Registration District No. 66 State File No. 181453
(If born in hospital or institution give name.) Prim. Registration District No. 2129 Local Registrar's No. 20
FULL NAME OF CHILD stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>F</u>	Twins or other? <u>and</u> { Number in order of birth } Legitimate? <u>yes</u>	Date of birth <u>May 19</u> 19 <u>30</u> (Month) (Day) (Year)
-----------------------	--	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 9 (a) Born alive and now living 8
Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME <u>Jacob Gaiser</u>	FULL MAIDEN NAME <u>Bessie Wescott</u>
Residence (Usual place of abode) <u>Winchester</u>	Residence (Usual place of abode) <u>Winchester</u>
If nonresident, give place and State _____	If nonresident, give place and State _____
Color or race <u>W</u> Age at last Birthday <u>53</u> (Years)	Color or race <u>W</u> Age at last Birthday <u>40</u> (Years)
Birthplace <u>Germany</u> (City and State or Country)	Birthplace <u>North Dakota</u> (City and State or Country)
Occupation <u>Farmer</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 5:30 P. M. on the date above stated.

(Signature) Ralph M. Alley M.D.
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Winchester, Idaho
Filed 6/24 1930 R. M. Alley
Registrar.

RECEIVED
 1914
 MAY 10
 10 11 AM
 1914

STATE OF TEXAS
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS

181453

CERTIFICATE OF BIRTH

Registration District No. _____ State File No. _____
 Birth Registration District No. _____ Local Registration No. _____
 FULL NAME OF CHILD _____
 OF _____ (Indicate the word "child" for name of child)
 Sex of _____ Date of Birth _____
 (Male) (Female) (Month) (Day) (Year)
 Number of child of this mother, including previous births _____
 Number of previous marriages _____
 Name of father _____
 Name of mother _____
 Residence (Usual place of abode) _____
 If nonresident, give place and State _____
 Color or race _____ Age at last birthday _____
 Birthplace _____ (City and State or Country)
 Occupation _____ (City and State or Country)
 Occupation of attending physician or midwife _____

I hereby certify that I attended the birth of this child, who was _____ at _____
 on the date above stated.
 (Signature) _____
 Physician or midwife
 Address _____
 Where there was no attending physician or midwife, then the father, household head, or other person should make this return. A statement showing other evidence of the birth of the child.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20742

PLACE OF DEATH
County of Lewis
City of Winchester

Registration District No. 60
Primary Registration District No. 2129
(No.)

Local Registrar's No. 8

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Still Birth

(a) Residence. No. St.

(Usual place of abode)
Length of residence in city or town where death occurred. 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE white	5. Single, Married, Widowed, or Divorced (write the word) —
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ?		
6. DATE OF BIRTH (month, day and year) May 14, 1930		
7. AGE Full Term	Years —	Months —
		Days —
		If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		

9. BIRTHPLACE (city or town) Winchester, Idaho
(State or country)

10. NAME OF FATHER Jacob Gaiser
11. BIRTHPLACE OF FATHER (city or town) Germany
12. MAIDEN NAME OF MOTHER Bessie Westcott
13. BIRTHPLACE OF MOTHER (city or town) North Dakota

14. Informant Jacob Gaiser
(Address) Winchester, Idaho

15. Filed 6/21, 1930. R. B. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 19, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19, 1930, to May 19, 1930, and that I last saw her alive on May 19, 1930, and that death occurred, on the date stated above, at 5:20 P.M.
The CAUSE OF DEATH* was as follows:
Still Birth.

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Shoulder Presentation. Diff. Delivery. (duration) yrs. mos. ds.

18. Where was disease contracted? ?
if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no

What test confirmed diagnosis?
(Signed) Ralph M. Alley, M.D.
May 20, 1930 (Address) Winchester, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Winchester, Idaho Date of Burial 6/20 1930

20. Undertaker J. Gaiser Address Winchester

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S 181540

County of Myer
City of Idaho
No. 367-220035-442 St. Registration District No. 96 State File No. 181540
Hospital St. Joseph's Primary Registration District No. 1009 Local Registrar's No. _____
FULL NAME OF CHILD Patricia Cox
(Certificate of no value without full name of child)

Sex of Child female Twin Triplet or other? 1 and { Number in order of birth 1 Legitimate? yes Date of birth May 20 1930
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Whitman Cox</u>	<u>Lewiston, Ida</u>	<u>Beatrice Musgraw</u>	<u>same</u>
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>20</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>21</u> (Years)
BIRTHPLACE <u>Ida</u>		BIRTHPLACE <u>Wash.</u>	
OCCUPATION <u>laborer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive { Stillborn } at 11 20 p. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

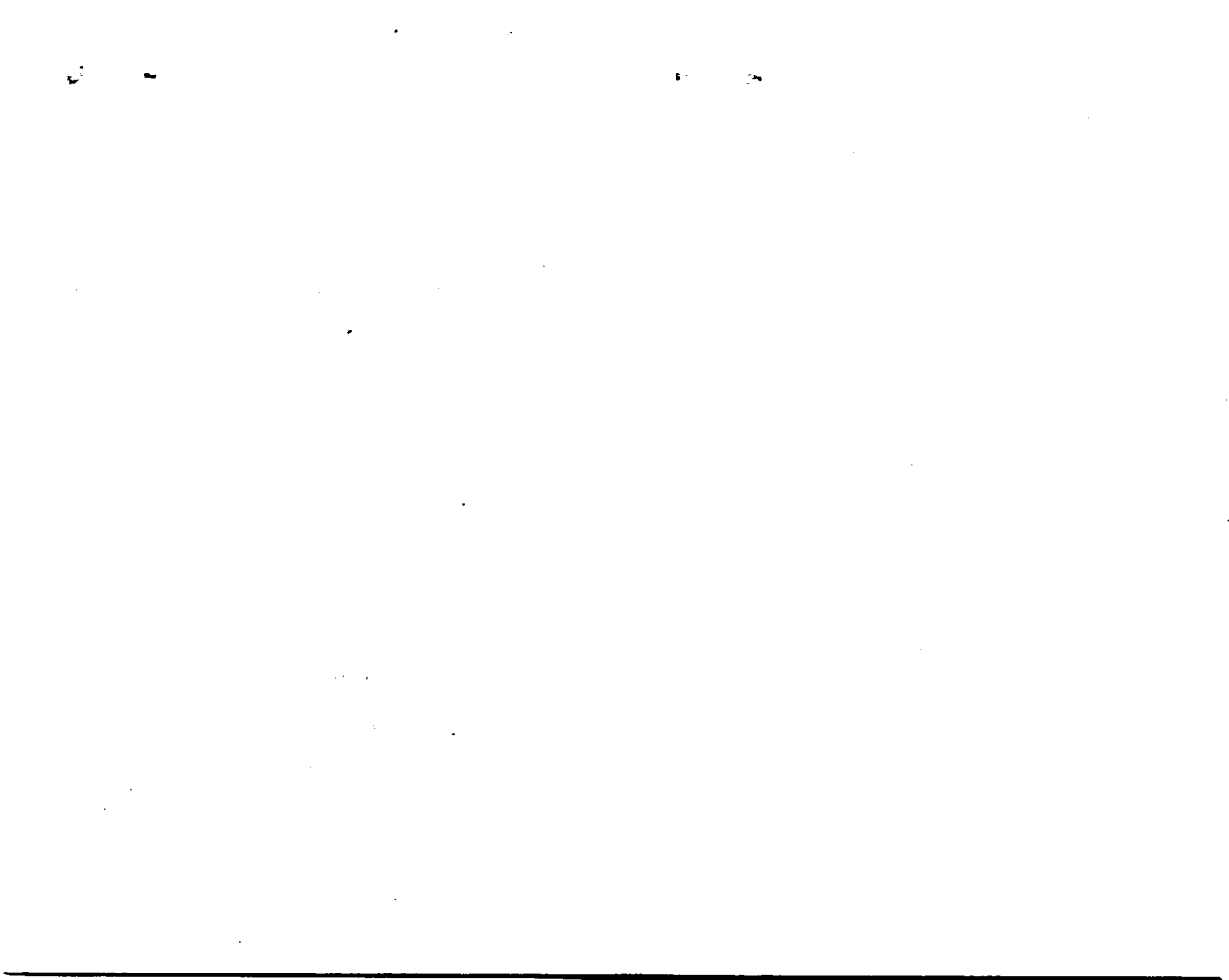
Give names added from a supplemental report. _____, 192____

(Signature) William P. Habel (Physician or midwife)
Lewiston, Ida

Address _____
Filed 6-1 1930 J. M. Lyle Registrar.

Registrar.

Registrar.



181540 WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. *211*

PLACE OF DEATH
County of Nez Perce.
City of Lewiston.

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital.)

Local Registrar's No. *268*

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Patricia Lee Cox.(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Female. 4. COLOR OR RACE White. 5. Single, Married, Widowed, or Divorced (write the word) v Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 20th, 1930.

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
-0- -0- -0-

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston,
(State or country) Idaho.

10. NAME OF FATHER Whitman B. Cox.

11. BIRTHPLACE OF FATHER (city or town) Lewiston,
(State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Mary Beatrice Musgrave.

13. BIRTHPLACE OF MOTHER (city or town) Walla Walla,
(State or Country) Washington.

14. Informant Whitman B. Cox.
(Address) Lewiston, Idaho.

15. Filed 6-1, 1930 J. M. Lytle
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 20th, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 19, to, 19.

that I last saw h. alive on, 19.

and that death occurred, on the date stated above, at.

The CAUSE OF DEATH* was as follows:

Asphyxia.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos.

(duration) yrs. mos.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *William J. Lytle.*, M.5/21/30., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Lewiston, Idaho. 5/22/30.
19

20. Undertaker Address

Brower-Wann Company. Lewiston, Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

316522-035-291
PLACE OF BIRTH

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

County of _____
City of Butte

No. _____ St. _____

(If born in hospital or institution
give name.)

Registration District No. 96 State File No. 181562

Prim. Registration District No. 1009 Local Registrar's No. _____

FULL NAME OF CHILD William Lawrence

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>4 22 1930</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? 1% silver nitrate

Number of child of this mother, including present birth 2 (a) Born alive and now living 2

Born alive but now dead _____ Stillborn _____

FATHER
FULL NAME H. Lawrence

Residence (Usual place of abode) Butte, Ida

If nonresident, give place and State _____

Color or race Indian Age at last Birthday 47
(Years)

Birthplace Butte, Ida
(City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Ellen Branskan

Residence (Usual place of abode) Butte, Ida

If nonresident, give place and State _____

Color or race Indian Age at last Birthday 35
(Years)

Birthplace Butte, Ida
(City and State or Country)

Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 7:45 P. M.
on the date above stated.

(Signature) O. C. Carson

(Physician or midwife)

{ *Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }

Address _____

Filed Jan 1 1930 Susan E Bruce
Registrar.

noD

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

249 213 040 215
PLACE OF BIRTH
County of Blaine MAY 24 1930
City of Wallace

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 181623

No. Pr St. Pr
Registration District No. 70 State File No. 35
Prim. Registration District No. 101 Local Registrar's No. 35

FULL NAME OF CHILD

Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>F</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>4 - 17 - 1930</u> (Month) (Day) (Year)
-----------------------	---	---	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 0

Born alive but now dead 2 Stillborn 2

FATHER FULL NAME <u>Chester H. Smiley</u>	MOTHER FULL MAIDEN NAME <u>Mary Banks</u>
--	--

Residence (Usual place of abode) <u>Burke, Ida</u>	Residence (Usual place of abode) <u>Burke Ida</u>
--	---

If nonresident, give place and State

Color or race <u>White</u> Age at last Birthday <u>25</u>	Color or race <u>White</u> Age at last Birthday <u>19</u>
---	---

Birthplace <u>Kissel Mills, Mo</u>	Birthplace <u>Porter, Okla</u>
------------------------------------	--------------------------------

Occupation <u>Miner</u>	Occupation <u>Housewife</u>
-------------------------	-----------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive Stillborn at 12:40 P. M. on the date above stated.

(Signature) D. A. Mowery
Physician or midwife

Address Wallace, Ida

Filed May 5 1930 L. R. Ziegler
Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

CONFIDENTIAL

[illegible]

It has been suggested that the use of the word "advice" is not appropriate in this context. The word "advice" is used in the text to refer to the information provided by the subject, which is not necessarily a recommendation or suggestion. The word "advice" is used in the text to refer to the information provided by the subject, which is not necessarily a recommendation or suggestion.

14

五、**其他**

11 November 1964

[Illegible handwritten notes]

DATE OF ATTENDING PHYSICIAN'S EXAMINATION

SECRET

"I don't think there are any more of these things," said the man. "I don't think there are any more of these things," said the man. "I don't think there are any more of these things," said the man.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 16572

PLACE OF DEATH
County of Shoshone
City of Malloch

Registration District No. 70

Primary Registration District No. 10

Local Registrar's No. 40

(No. Providencia Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant of Chester H. Smiley(a) Residence. No. Burke, Idaho St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Wallace Idaho
(State or country)10. NAME OF FATHER Chester H. Smiley11. BIRTHPLACE OF FATHER (city or town) Kissee Mills Missouri
(State or Country)12. MAIDEN NAME OF MOTHER Mary Banks13. BIRTHPLACE OF MOTHER (city or town) Porter Oklahoma
(State or Country)14. Informant Chester H. Smiley
(Address) Burke, Idaho15. Filed 4-14, 1930 J. L. Lingley
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 17 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19_____, to _____, 19____.

that I last saw him alive on _____, 19____.

and that death occurred, on the date stated above, at 12 P.M.

The CAUSE OF DEATH was as follows:

Stillborn

(duration) yrs. mos. ds.

CONTRIBUTION (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of _____Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. M. W. Mowery, M. D.1930 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Wallace Idaho April 19 193020. Undertaker Bruce E. Mowery Address Wallace

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 181631

County of Shoshone

City of Kellogg

No. 465 718 040 235 St.

(If born in hospital or institution
give name.)

Registration District No. 123 State File No.

Prim. Registration District No. 2204 Local Registrar's No. 60

FULL NAME OF CHILD

Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child

Male

Twin
Triplet
or other?
(To be answered only in event of plural births)

and { Number
in order
of birth

Legiti-
mate? yes

Date of
birth

May 18
(Month) (Day)

1930
(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 0

Born alive but now dead 1 Stillborn May 18th

FATHER

FULL
NAME

Henry Doersdorf

Residence (Usual place of abode) Kellogg, Idaho

If nonresident, give place and State

Color or race White Age at last Birthday 34

(Years)

Birthplace

Minnesota
(City and State or Country)

Occupation

MOTHER

FULL
MAIDEN
NAME

Wilomia Bleisner

Residence (Usual place of abode) Kellogg, Idaho

If nonresident, give place and State

Color or race White Age at last Birthday 27

(Years)

Birthplace

Idaho
(City and State or Country)

Occupation

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 29 M.
on the date above stated. { Stillborn }

(Signature)

W. J. Gentry
Physician

(Physician or midwife)

Address

Kellogg, Idaho

Filed May 20 1930

Miss Helen G. Biele
Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

181691

Registration District No. 10 State File No. 10
Birth Registration District No. 10 Local Registrar's No. 10

CHILD NAME OF CHILD

Sex of Child	Male	Female
Color of Child	White	Black
Birth Date	10-10-1916	
Birth Time	10:30	

What prophylaxis was used to prevent (containing) Neonatorum?

Number of child of this mother (including present infant) (a) born alive and now living (b) born still and now dead

FATHER NAME: [illegible]
MOTHER NAME: [illegible]

Residence (Usual place of abode) [illegible]
If nonresident, give place and State [illegible]
Color of hair [illegible] Age at last birthday (Years) [illegible]
Height [illegible] Weight [illegible] (Circumference of Chest) [illegible]
(Circumference of Arm) [illegible]

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that attended the birth of this child, who was [illegible] on the date above stated.

(Signature) [illegible]
Address [illegible]
City [illegible]

*Where there was no attending physician or midwife, then the father, mother, etc. should make this report. A stillborn child is one that is born dead, not showing signs of life at the time of birth.

THIS IS TO CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ON THE DATE AND AT THE PLACE AND TO THE PARENTS HEREIN SET FORTH AND THAT THE CHILD WAS REGISTERED IN THE BIRTH RECORDS OF THE BUREAU OF VITAL STATISTICS OF THE DEPARTMENT OF HEALTH OF THE DISTRICT OF COLUMBIA.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71111

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123

Primary Registration District No. 2201

Local Registrar's No. 28

(If death occurred in a hospital or institution, give its name instead of street and number.)
(No. _____)

2. FULL NAME Baby Doernberg

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX M. 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
— — — —

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Kellogg, Ida
(State or country)10. NAME OF FATHER Henry Doernberg11. BIRTHPLACE OF FATHER (city or town) Minnesota
(State or Country)12. MAIDEN NAME OF MOTHER Mrs. Bleisner13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)14. Informant Henry Doernberg
(Address) Kellogg, Ida15. Filed May 30, 1930 Mrs. Helen M. Brice
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 18 1930

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 18th, 1930; to _____, 19____

that I last saw h_____ alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born. Altered on part of mother.

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? noWhat test confirmed diagnosis? Macroscopic of body(Signed) W. E. Lindsey, M. D.May 21, 1930 (Address) Kellogg, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Kellogg, Ida May 20 1930

20. Undertaker

Address

M. P. Thornhill Kellogg, Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL**, **SUICIDAL**, or **HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—~~Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.~~

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 1658

County of Blaine

City of Blaine

No. 162241232 St.

Blaineville, Co. La. Utah

(If born in hospital or institution
give name.)

Registration District No. 37 State File No. 1658

Prim. Registration District No. 2085 Local Registrar's No.

FULL NAME OF CHILD Elma Mayce

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number of birth of birth	Legiti- mate? <u>yes</u>	Date of birth <u>5 - 24 - 1930</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 11 (a) Born alive and now living 10

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Nathan Reuben Mayce

Residence (Usual place of abode) Mustang, Ida

If nonresident, give place and State

Color or race White Age at last Birthday 43

Birthplace Huntsville, Utah (Years)

(City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Minnie Baise Laker

Residence (Usual place of abode) Mustang, Ida

If nonresident, give place and State

Color or race White Age at last Birthday 39

Birthplace St. Charles, Idaho (Years)

(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive 8 15 A. M.
on the date above stated. Stillborn

(Signature) J. A. Davis

(Physician or midwife)

Address Kimberly, Idaho

Filed 6 - 4 - 1930 Clifford J. Smith

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



1. 2. 3.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

245709 042 381
PLACE OF BIRTH
RECEIVED JUN 9 1930
County of Twin Falls
City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 181675

No. _____ St. _____
Twin Falls Co. Ind Recd Registration District No. 37 State File No. _____

(If born in hospital or institution
give name.)

Prim. Registration District No. 2085 Local Registrar's No. _____

FULL NAME OF CHILD Thomas Adolph Kinkel
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>5 - 9</u>	19 <u>30</u>
	(To be answered only in event of plural births)			(Month)	(Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 5 (a) Born alive and now living 4
Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Dale McForest Kinkel
Residence (Usual place of abode) Amsterdam
If nonresident, give place and State Idaho
Color or race White Age at last Birthday 38
Birthplace Wab County - Missouri
(City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Witch Chandler
Residence (Usual place of abode) Amsterdam, Ida
If nonresident, give place and State _____
Color or race White Age at last Birthday 34
Birthplace Chicago - Ill
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 40 P. M.
on the date above stated. { Stillborn }

(Signature) Charles R. Scott

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Twin Falls - Idaho
Filed 6 - 9 - 1930 Clifford G. Smith
Registrar.

JOHN J. MURPHY, JR.

Noted. 10. Estimated cost of 1.000.000.000

Form T-100 (Rev. 1-1-60)

...to the fact that the ...

[illegible]

What prophylactic was used to prevent syphilis? Neurosyphilis?

Number of bill of the number, technology present with (a) Born alive and now living

Just who and what they

NOTES

સાદરે આભાર

RESULTAT

2.250

SECRET

Wanda to David (Lynn) - 1960

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

It is recommended that the following be done:

Order of 1866

(b)(7)(C), (b)(7)(D)

(JAN 1971)

(City and State or County)

(Country)

TESTIMONY OF ATTENDING PHYSICIAN OR MIDWIFE.

I deeply regret that I attended the birth of this child, who was (William) and he later became a doctor.

(01002912)

There is one that neither member nor
etc. should make the point. A little
or, in other words, the fact, however
it was there was no attending physician.

245-766A

5000

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No.

PLACE OF DEATH
County Blaine Falls
City of Blaine Falls

Registration District No. 37
Primary Registration District No. 2085

Local Registrar's No.

No. Adolph Bunkel

(No.)
If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bunkel

(a) Residence. No. Amsterdam Idaho St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

10. NAME OF FATHER D. Bunkel

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER Putzelander

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant D. Bunkel
(Address) Amsterdam Idaho

15. Filed _____, 19____

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 9 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____
that I last saw him alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

Oligohydramnion.

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Charles R. Scott, M. D.

May 10, 1930 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Blaine Falls May 10 1930

20. Undertaker J. H. Seale Blaine Falls

206

181675 A

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

697111044815
~~PLACE FOR BIRTH~~ JUN 14 1930

County of Washington
City of Weiser
No. _____ St. _____

Moulhead
(If born in hospital or institution
give name.)

FULL NAME OF CHILD

Registration District No. 86 State File No. S 181696
Prim. Registration District No. 1010 Local Registrar's No. 27
Gene Wiggins
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	{ and } Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>3 - 11 - 1930</u> (Month) (Day) (Year)
--------------------------	---	---	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? Arg. Ma 3-1-90 and

Number of child of this mother, including present birth. 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>Stomer Wiggins</u>	MOTHER FULL MAIDEN NAME <u>Elsie Yantley</u>
---	---

Residence (Usual place of abode) _____

If non-resident, give place and State Midvale Ida.

Color or race White Age at last Birthday 23 (Years)

Birthplace Midvale Ida. (City and State or County)

Occupation Farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive }
on the date above stated. { Stillborn } at 11 A. M. M.

(Signature) Ernest O. Frisney

Physician
(Physician or midwife)

Address _____

Filed 5/3/30 19 W. H. Kunkle
Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

343-131

保

10-10-68

LETTER TO THE EDITOR

It alludes, especially the word "sublimed", not name of class.

[illegible]

...the use of the word "Zoonosis" is not to prevent

1. Name of child of the mother including present birth (a) Born alive and now living

14-00000

117044112

HUTTON

民國二十九年六月

運轉自如

Resistance (Unit load of 100 lbs)

APR 11 1964

7081401-10

RECEIVED
JAN 10 1967

CERTIFICATE OF ATTENDING PHYSICIAN OF MICHIGAN

10-10-68

I have said that I attended the birth of this child, who was -

10-10-68

(930150342)

[Faint, illegible text at the bottom of the page]

2010年10月

2014

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70043

PLACE OF DEATH

County of Washington
City of Wise

Registration District No. 86
Primary Registration District No. 1910

Local Registrar's No. 16

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leise Wiggins(a) Residence. No. Madison Idg St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W 5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Hoover Wiggins
(Address) Madison Idg

15. Filed Mar 14, 1930 J. K. Harrison
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw h. _____ alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Immature Still
Birth at 7 1/2 mo.
(duration) yrs. mos. ds.

CONTRIBUTORY Toxemia
(Secondary) of pregnancy (duration) yrs. 5 mos. ds.

18. Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Ernesto J. Luning M. D.

3-11, 1930 (Address) Wear Idg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Madison Idg Date of Burial 3-12-1930

20. Undertaker

H. C. Northern Address Wear Idg

181696

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

396-110001-466

PLACED RECEIVED

JUL 9 1930

County of.....

City of.....

No. St.

St. Lakes
(If born in hospital or institution
give name.)

FULL NAME OF CHILD.....

Registration District No. *3* State File No. *181785*

Prim. Registration District No. *1004* Local Registrar's No. *280*

(Stillborn)

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <i>M</i>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <i>Y</i>	Date of birth <i>June 10</i> 19 <i>30</i> (Month) (Day) (Year)
-----------------------	---	-----	--------------------------------	---------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? *Argyrol*

Number of child of this mother, including present birth. *5* (a) Born alive and now living *1*

Born alive but now dead *4* Stillborn *4*

FATHER FULL NAME <i>Ward A. Trope</i>	MOTHER FULL MAIDEN NAME <i>Alpha Mooney</i>
--	--

Residence (Usual place of abode) *2315 Woodlawn*

If non-resident, give place and State.....

Color or race *W* Age at last Birthday *40* (Years)

Birthplace *Missouri* (City and State or County)

Occupation *Clerk*

If non-resident, give place and State.....

Color or race *W* Age at last Birthday *38* (Years)

Birthplace *Missouri* (City and State or County)

Occupation *Housewife*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was *Born alive* *Stillborn* at *2⁰⁰* *A.* M.
on the date above stated.

(Signature) *AJ Coats*

(Physician or midwife)

Address *521 Eastman Blvd*

Filed *6-10-1930 W. D. Rhodes*

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

1. Name of child
 2. Date of birth
 3. Sex
 4. Race
 5. Color
 6. Height
 7. Weight
 8. Age
 9. Education
 10. Occupation
 11. Religion
 12. Marital status
 13. Number of children
 14. Name of father
 15. Name of mother
 16. Name of guardian
 17. Name of teacher
 18. Name of doctor
 19. Name of dentist
 20. Name of pharmacist
 21. Name of veterinarian
 22. Name of optician
 23. Name of podiatrist
 24. Name of chiropractor
 25. Name of psychologist
 26. Name of psychiatrist
 27. Name of social worker
 28. Name of nurse
 29. Name of physician assistant
 30. Name of medical technician
 31. Name of dental technician
 32. Name of pharmacy technician
 33. Name of laboratory technician
 34. Name of radiology technician
 35. Name of respiratory therapist
 36. Name of physical therapist
 37. Name of occupational therapist
 38. Name of speech therapist
 39. Name of dietitian
 40. Name of nutritionist
 41. Name of health educator
 42. Name of public health worker
 43. Name of community health worker
 44. Name of case manager
 45. Name of care coordinator
 46. Name of patient navigator
 47. Name of medical interpreter
 48. Name of medical translator
 49. Name of medical scribe
 50. Name of medical coder
 51. Name of medical biller
 52. Name of medical records manager
 53. Name of medical office manager
 54. Name of medical assistant
 55. Name of medical receptionist
 56. Name of medical secretary
 57. Name of medical clerk
 58. Name of medical janitor
 59. Name of medical custodian
 60. Name of medical security guard
 61. Name of medical driver
 62. Name of medical porter
 63. Name of medical orderly
 64. Name of medical aide
 65. Name of medical volunteer
 66. Name of medical intern
 67. Name of medical resident
 68. Name of medical fellow
 69. Name of medical student
 70. Name of medical trainee
 71. Name of medical apprentice
 72. Name of medical journeyman
 73. Name of medical master
 74. Name of medical expert
 75. Name of medical specialist
 76. Name of medical consultant
 77. Name of medical advisor
 78. Name of medical reviewer
 79. Name of medical auditor
 80. Name of medical investigator
 81. Name of medical analyst
 82. Name of medical researcher
 83. Name of medical scientist
 84. Name of medical professor
 85. Name of medical lecturer
 86. Name of medical instructor
 87. Name of medical supervisor
 88. Name of medical manager
 89. Name of medical executive
 90. Name of medical administrator
 91. Name of medical director
 92. Name of medical officer
 93. Name of medical captain
 94. Name of medical lieutenant
 95. Name of medical sergeant
 96. Name of medical corporal
 97. Name of medical private
 98. Name of medical recruit
 99. Name of medical trainee
 100. Name of medical cadet

1. Name of child
 2. Date of birth
 3. Sex
 4. Race
 5. Color
 6. Height
 7. Weight
 8. Age
 9. Education
 10. Occupation
 11. Religion
 12. Marital status
 13. Number of children
 14. Name of father
 15. Name of mother
 16. Name of guardian
 17. Name of teacher
 18. Name of doctor
 19. Name of dentist
 20. Name of pharmacist
 21. Name of veterinarian
 22. Name of optician
 23. Name of podiatrist
 24. Name of chiropractor
 25. Name of psychologist
 26. Name of psychiatrist
 27. Name of social worker
 28. Name of nurse
 29. Name of physician assistant
 30. Name of medical technician
 31. Name of dental technician
 32. Name of pharmacy technician
 33. Name of laboratory technician
 34. Name of radiology technician
 35. Name of respiratory therapist
 36. Name of physical therapist
 37. Name of occupational therapist
 38. Name of speech therapist
 39. Name of dietitian
 40. Name of nutritionist
 41. Name of health educator
 42. Name of public health worker
 43. Name of community health worker
 44. Name of case manager
 45. Name of care coordinator
 46. Name of patient navigator
 47. Name of medical interpreter
 48. Name of medical translator
 49. Name of medical scribe
 50. Name of medical coder
 51. Name of medical biller
 52. Name of medical records manager
 53. Name of medical office manager
 54. Name of medical assistant
 55. Name of medical receptionist
 56. Name of medical secretary
 57. Name of medical clerk
 58. Name of medical janitor
 59. Name of medical custodian
 60. Name of medical security guard
 61. Name of medical driver
 62. Name of medical porter
 63. Name of medical orderly
 64. Name of medical aide
 65. Name of medical volunteer
 66. Name of medical intern
 67. Name of medical resident
 68. Name of medical fellow
 69. Name of medical student
 70. Name of medical trainee
 71. Name of medical apprentice
 72. Name of medical journeyman
 73. Name of medical master
 74. Name of medical expert
 75. Name of medical specialist
 76. Name of medical consultant
 77. Name of medical advisor
 78. Name of medical reviewer
 79. Name of medical auditor
 80. Name of medical investigator
 81. Name of medical analyst
 82. Name of medical researcher
 83. Name of medical scientist
 84. Name of medical professor
 85. Name of medical lecturer
 86. Name of medical instructor
 87. Name of medical supervisor
 88. Name of medical manager
 89. Name of medical executive
 90. Name of medical administrator
 91. Name of medical director
 92. Name of medical officer
 93. Name of medical captain
 94. Name of medical lieutenant
 95. Name of medical sergeant
 96. Name of medical corporal
 97. Name of medical private
 98. Name of medical recruit
 99. Name of medical trainee
 100. Name of medical cadet

RECEIVED JUL 9 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 70771

PLACE OF DEATH

County of Ada

City of Boise

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No. 1004

(No. St Lukes Hospital.)

Local Registrar's No. 173

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Melvin Kenneth Troxel.

(a) Residence. No. 2315. Woodlawn Street. St.

(Usual place of abode.)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

(If nonresident give city or town and State.)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male.

4. COLOR OR RACE

White.

5. Single, Married, Widowed,
or Divorced (write the word.)

Single.

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

June. 10. 1930.

7. AGE

Years

Months

Days

If LESS than 1 day.

hrs. or
min.

0

0

0

0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or

particular kind of work

None.

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Idaho.
(State or country)

10. NAME OF FATHER

Ward. A. Troxel.

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

Missouri.

12. MAIDEN NAME OF MOTHER

Alpha. B. Mooney.

13. BIRTHPLACE OF MOTHER (city or town)
(State or County)

Missouri.

14.

Informant
(Address)

Ward. A. Troxel.

2315. Woodlawn St. Boise, Idaho.

15.

Filed

6-10 1930

W. H. Rhodes

Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1930
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him alive on

19

and the death occurred, on the date stated above, at 2 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1930

(Address)

19. Place of Burial, Cremation, or Removal

Date of Burial

Morris Hill Cemetery.

June. 10. 30.

20. Undertaker

Address

Summers & Krebs.

Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of** (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE RECEIVED JUL 2 1930
County of Cannock STATE OF IDAHO
City of Lava Hot Springs DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
No. 236115003 764 CERTIFICATE OF BIRTH S 181820
Registration District No. 84 State File No. 84
(If born in hospital or institution give name.)
Prim. Registration District No. 2161 Local Registrar's No. 788

FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth {	Legiti- mate? <u>yes</u>	Date of birth <u>June 15 1930</u> (Month) (Day) (Year)
--------------------------	---	--	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 6 (a) Born alive and now living 5
Born alive but now dead _____ Stillborn 1

FULL NAME <u>John Muel Bloxham</u> Residence (Usual place of abode) <u>Lava H S</u> If nonresident, give place and State _____ Color or race <u>White</u> Age at last Birthday <u>33</u> Birthplace <u>Douney Ida</u> (Years) (City and State or Country) Occupation <u>Labourer</u>	FATHER FULL MAIDEN NAME <u>Linda Verina Collier</u> Residence (Usual place of abode) <u>Lava Hot Springs</u> If nonresident, give place and State _____ Color or race <u>White</u> Age at last Birthday <u>29</u> Birthplace <u>Bingham City Utah</u> (Years) (City and State or Country) Occupation <u>Housewife</u>	MOTHER
--	--	--------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {Born alive
Stillborn } at 7:45 A M.
on the date above stated.

(Signature) C. A. Rich
M.D.
(Physician or midwife)

Address Lava Hot Springs Ida

Filed June 30 1930 W. G. G. Fitz
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

NOT RECORDED

11. To ensure the word "Billion" is used in the same manner as in the 1950s, the word "Billion" shall be used in the same manner as in the 1950s.

1-11-41
1-11-41

100-100000 (a) Born alive and now living

modèle

SECRET

1. NAME
 2. ADDRESS
 3. CITY
 4. STATE
 5. ZIP
 6. PHONE
 7. TELETYPE
 8. TELEFAX
 9. TELEMAIL
 10. TELEFAX
 11. TELEMAIL
 12. TELEFAX
 13. TELEMAIL
 14. TELEFAX
 15. TELEMAIL
 16. TELEFAX
 17. TELEMAIL
 18. TELEFAX
 19. TELEMAIL
 20. TELEFAX
 21. TELEMAIL
 22. TELEFAX
 23. TELEMAIL
 24. TELEFAX
 25. TELEMAIL
 26. TELEFAX
 27. TELEMAIL
 28. TELEFAX
 29. TELEMAIL
 30. TELEFAX
 31. TELEMAIL
 32. TELEFAX
 33. TELEMAIL
 34. TELEFAX
 35. TELEMAIL
 36. TELEFAX
 37. TELEMAIL
 38. TELEFAX
 39. TELEMAIL
 40. TELEFAX
 41. TELEMAIL
 42. TELEFAX
 43. TELEMAIL
 44. TELEFAX
 45. TELEMAIL
 46. TELEFAX
 47. TELEMAIL
 48. TELEFAX
 49. TELEMAIL
 50. TELEFAX
 51. TELEMAIL
 52. TELEFAX
 53. TELEMAIL
 54. TELEFAX
 55. TELEMAIL
 56. TELEFAX
 57. TELEMAIL
 58. TELEFAX
 59. TELEMAIL
 60. TELEFAX
 61. TELEMAIL
 62. TELEFAX
 63. TELEMAIL
 64. TELEFAX
 65. TELEMAIL
 66. TELEFAX
 67. TELEMAIL
 68. TELEFAX
 69. TELEMAIL
 70. TELEFAX
 71. TELEMAIL
 72. TELEFAX
 73. TELEMAIL
 74. TELEFAX
 75. TELEMAIL
 76. TELEFAX
 77. TELEMAIL
 78. TELEFAX
 79. TELEMAIL
 80. TELEFAX
 81. TELEMAIL
 82. TELEFAX
 83. TELEMAIL
 84. TELEFAX
 85. TELEMAIL
 86. TELEFAX
 87. TELEMAIL
 88. TELEFAX
 89. TELEMAIL
 90. TELEFAX
 91. TELEMAIL
 92. TELEFAX
 93. TELEMAIL
 94. TELEFAX
 95. TELEMAIL
 96. TELEFAX
 97. TELEMAIL
 98. TELEFAX
 99. TELEMAIL
 100. TELEFAX

SENT A

(photo to come later) 200-111-1111

It is requested that you advise the Bureau of the results of your investigation.

~~CONFIDENTIAL - SECURITY INFORMATION~~

(b)(7)(C)

(City and State or Country)

පොත්පොත

10. CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hardly recall that I attended the birth of this child, who was [redacted]

(STANDARD)

(Physician or nurse)

REYNOLDS

1219

shows other evidence of life after birth. Child is one last neither breathe nor etc., should make this error. A stillborn or mangled, then the latter, homebound; **Where there was no attending physician

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70822

PLACE OF DEATH
County of Bannock
City of Lava Hot Springs
Registration District No. 84
Primary Registration District No. 2161

Local Registrar's No. 186

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stilbuth

(a) Residence. No. Lava Hot Springs St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of None
6. DATE OF BIRTH (month, day and year)
7. AGE Years Months Days If LESS than 1 day, hrs. or min. 0
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (city or town) Lava Hot Springs (State or country) Idaho
10. NAME OF FATHER John Merle Bloxham
11. BIRTHPLACE OF FATHER (city or town) Downey (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Linda Verina Godfrey
13. BIRTHPLACE OF MOTHER (city or town) Brigham City (State or Country) Utah

14. Informant John Merle Bloxham
(Address) Lava Hot Springs, Bannock Co. Idaho
15. Filed June 30, 1930 Mrs. G. J. Tuttle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 15 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from at birth June 15 1930 to _____, 19____, that I last saw him alive on never lived, 19____, and that death occurred, on the date stated above, at 7:45 a.m.
The CAUSE OF DEATH* was as follows:
Unknown (Died in utero at 6 mo gestation)

(duration) yrs. mos. ds.
CONTRIBUTORY Unknown
(Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? _____
Did an operation precede death? no Date of _____
Was there an autopsy? no
What test confirmed diagnosis? _____
(Signed) E. H. Rich M. D.
6-15-1930 (Address) Lava Hot Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal _____ Date of Burial _____
20. Undertaker _____ Address _____

181820 +

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH JUL 2 1930

County of Bancroft
City of Chesterfield
No. _____ St. _____

539106-003-265
(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 181822

Registration District No. 84 State File No. _____

Prim. Registration District No. 2161 Local Registrar's No. 786

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>June-6-</u> 19 <u>30</u> (Month) (Day) (Year)
--------------------------	---	-------	--------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1 (a) Born alive and now living _____

Born alive but now dead _____ Stillborn 1

FATHER
FULL NAME Joseph Godfrey Eliaison
Residence (Usual place of abode) Bancroft

If nonresident, give place and State _____

Color or race White Age at last Birthday 28
(Years)

Birthplace Logan Utah
(City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Ruby Bowman
Residence (Usual place of abode) Bancroft Ida

If nonresident, give place and State _____

Color or race White Age at last Birthday 23
(Years)

Birthplace Chesterfield Idaho
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive }
on the date above stated. { Stillborn } at 2:30 A. M.

(Signature) [Signature]
(Physician or midwife)

Address Bancroft Idaho

Filed June 30 1930 Mrs. G. G. Feb
Registrar

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

What prophylactic was used?

~~8-11-41 10:00 AM~~

NAME

2-11-1964

(continued)

NOTES

I have not returned.

Abstract

etc. should make this

to negative results are:

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 2 1930

 STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70824Local Registrar's No. 184County of BannockCity of ChesterfieldRegistration District No. 86Primary Registration District No. 2161(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

June 6 - 1930

7 AGE

Years

Months

Days

If LESS than
1 day, 2 hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Chesterfield Ida

10 NAME OF FATHER

Joseph Godfrey Eliason

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Logan Utah

12 MAIDEN NAME OF MOTHER

Kesby Bowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Chesterfield Idaho

14

Informant (Address)

Mr. J. G. Eliason
Bannock Ida

15

Filed June 30, 1930Mr. J. G. Eliason

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June - 6 - 1930
(Month) (Day) (Year)
 17 I HEREBY CERTIFY, That I attended deceased from June 6, 1930, to at birth, 19_____,
 that I last saw him alive on news paper, 19_____,
 and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Unknown
About 5 or 6 months before
pregnant
 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis?

(Signed) S. G. Felt, M. D.June 7, 1930 (Address) Bannock Ida
 *State the DISEASE CAUSING DEATH, or in deaths from VIO-
 LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
 and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

19

20. Undertaker

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

341 3112-2073-313
PLACE RECEIVED JUL 10 1930

County of Bannock
City of Paris
No. St. Anthony St.
Hoap

(If born in hospital or institution
give name.)

FULL NAME OF CHILD

Registration District No. 20 State File No. 181864
Prim. Registration District No. 161 Local Registrar's No. 9843

Stillborn (Cullen)

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u> </u>	{ and }	Number in order of birth <u> </u>	Legiti- mate? <u>yes</u>	Date of birth <u>6-12-</u> <u>1930</u>
(To be answered only in event of plural births)				(Month)	(Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth (a) Born alive and now living

Born alive but now dead Stillborn

FATHER
FULL NAME Lawrence Cullen

Residence (Usual place of abode) 320 N. Grant

If non-resident, give place and State

Color or race W Age at last Birthday 31

Birthplace Minodoka, Ida (Years)
(City and State or County)

Occupation Carpenter

MOTHER
FULL MAIDEN NAME Adeline Balcomb

Residence (Usual place of abode) 320 N. Grant

If non-resident, give place and State

Color or race W Age at last Birthday 23

Birthplace Kennecott, Wyo (Years)
(City and State or County)

Occupation H. W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive
on the date above stated. Stillborn at 2:50 A.M.

(Signature) W. Hoap

(Physician or midwife)

Address Paris, Idaho

Filed July 1 1930 Dr. J. R. Young

Registrar MS

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Where there are no attending physicians
a midwife, born the latest household
midwife, and a woman. A woman
said to one of the women, "I have not
shown after birth of the other child."

(Pregnancy)

I myself said that I attended the birth of the child, who was, however, in

REMARKS OF OTHER

THE NAME OF CHILD

Age of last birthday

Color of hair

Color of eyes

Birthplace

Occupation

EDUCATION OF CHILD

RELIGION OF CHILD

DATE OF BIRTH

TIME OF BIRTH

PLACE OF BIRTH

NAME OF MOTHER

NAME OF FATHER

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70815

PLACE OF DEATH

County of BarnackCity of PocatelloRegistration District No. 28Primary Registration District No. 216Local Registrar's No. 5844

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Cullen(a) Residence. No. 320 N. Grant St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OF RACE White 5. Single, Married, Widowed, or Divorced (write the word) —5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) June 12-19307. AGE Years Months Days If LESS than 1 day, hrs. or min.
Still Born

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. —(b) General nature of industry, business, or establishment in which employed (or employer) —(c) Name of employer —9. BIRTHPLACE (city or town) Pocatello
(State or country) Idaho10. NAME OF FATHER L. M. Cullen11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)12. MAIDEN NAME OF MOTHER Adelene Talcott13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)14. Informant L. M. Cullen
(Address) 320 N. Grant15. Filed 7-1, 1930Registrar J. R. Young

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 12 1930

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 12 1930 to June 12 1930
that I last saw him alive on June 12, 1930
and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Still bornCONTRIBUTORY (duration) yrs. mos. ds.
(Secondary) Albuminuria of mother

(duration) yrs. 1 mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date of —Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. W. Brothman M. D.
6-12, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountain View Date of Burial June 12 193020. Undertaker Schmuck Address C...

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

181864 +

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH 391 206-007 819

STATE OF IDAHO

County of Blaine
City of Reata, Ida
No. 243 No. 5th Ave - Bk.

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S
181878

Registration District No. 25 State File No. 181878
(If born in hospital or institution give name.)
Prim. Registration District No. 1st Local Registrar's No. 1st
FULL NAME OF CHILD Steebhorn Craney
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>—</u> and <u>—</u> Number in order of birth <u>—</u>	Legitimate? <u>Yes</u>	Date of birth <u>June 6 1930</u> (Month) (Day) (Year)
----------------------------	--	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? 15% Argrol

Number of child of this mother, including present birth — (a) Born alive and now living —
Born alive but now dead 1 Stillborn 1

FATHER FULL NAME <u>Oscar Craney</u> Residence (Usual place of abode) <u>243 No. 5th Ave</u>	MOTHER FULL MAIDEN NAME <u>Dee Wargrow</u> Residence (Usual place of abode) <u>243 No. 5th Ave</u>
--	--

It non-resident, give place and State <u>—</u> Color or race <u>Negro</u> Age at last Birthday <u>42</u> (Years) Birthplace <u>Texas</u> (City and State or County) Occupation <u>Janitor - C. S. Freight</u>	If non-resident, give place and State <u>—</u> Color or race <u>Negro</u> Age at last Birthday <u>38</u> (Years) Birthplace <u>Texas</u> (City and State or County) Occupation <u>Housewife</u>
---	---

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3:25 A. M. on the date above stated.
(Signature) D C Ray

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Reata, Ida
Filed June 19 1930 D C Ray Registrar

ST. LOUIS, MISSOURI
JANUARY 1, 1900
ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI
JANUARY 1, 1900
ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI
JANUARY 1, 1900
ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI
JANUARY 1, 1900
ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI
JANUARY 1, 1900
ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI
JANUARY 1, 1900
ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI
JANUARY 1, 1900
ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI
JANUARY 1, 1900
ST. LOUIS, MISSOURI

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PHYSICIAN

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back.

JUN 12 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 10127

PLACE OF DEATH

County of Bannock
City of Pocatello

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

(No. St Anthony's)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5826

2. FULL NAME

(a) Residence. No. 1243 N. 5th St.

(Usual place of abode.)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Colored 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 6, 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or
Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello Ida

10. NAME OF FATHER Oscar Craney

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Texas

12. MAIDEN NAME OF MOTHER Delia Hargrave

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Texas

14. Informant (Address) Oscar Craney

15. Filed June 6, 1930 J. R. Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 6, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred, on the date stated above, at.....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

died in uterus 14 wks
and lied around
arms.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. C. Roy, M. D.
6-6, 1930 (Address)

19. Place of Burial, Cremation, or Removal Date of Burial
Pocatello Ida June 6, 1930

20. Undertaker Address
H. L. McMan Pocatello

121878 +

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: Cerebro spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "croup"); Typhoid Fever (never report Typhoid pneumonia); Lobar Pneumonia; Bronchopneumonia ("pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

RECEIVED JUL 10 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

181881

County of Bannock 55-1-105
City of Pocatello 2-003415
No. Arbon, Ida. Res.

General
(If born in hospital or institution
give name.)

Registration District No. 28 State File No. 181881
Prim. Registration District No. 161 Local Registrar's No. 9872

FULL NAME OF CHILD Stillborn Evans
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>—</u>	Number in order of birth <u>—</u>	Legitimate? <u>yes</u>	Date of birth <u>June 5 1930</u> (Month) (Day) (Year)
--------------------------	---------------------------------	-----------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 5 (a) Born alive and now living 2
Born alive but now dead — Stillborn 3

FATHER
FULL NAME Leslie M. Evans
Residence (Usual place of abode) Arbon, Ida.

MOTHER
FULL MAIDEN NAME Ella Daniels
Residence (Usual place of abode) Arbon, Ida.

If non-resident, give place and State —
Color or race White Age at last Birthday 28 (Years)
Birthplace Ignacio, Ida. (City and State or County)
Occupation Farmer

If non-resident, give place and State —
Color or race White Age at last Birthday 30 (Years)
Birthplace Malad, Ida. (City and State or County)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 6:00 P. M. on the date above stated.

(Signature) D. C. Ray
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Pocatello
Filed July 19 1930 L. J. Young Registrar
m

There is no attending physician
 or other person in the household
 who is a member of the same. A child
 who is not a member of the same
 is not a member of the same.

Address

(Signature)

I hereby certify that I attended the birth of this child who was born

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

Occupation

(City and State of Birth)

Birthplace

(Color of race)

If non-white, give date and place

(Date of birth)

Religion

(Sex)

Weight

Height

Age

Sex

(If stillborn, state date and place of death)

(If stillborn, state date and place of death)

(If stillborn, state date and place of death)

(If stillborn, state date and place of death)

(If stillborn, state date and place of death)

(If stillborn, state date and place of death)

(If stillborn, state date and place of death)

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUL 10 1930

PLACE OF BIRTH

County of Bannock

City of Pocatello

No. 557107 003423 St.

Lynn Hospital

(If born in hospital or institution give name.)

FULL NAME OF CHILD

Registration District No. 24

State File No.

Prim. Registration District No. 161

Local Registrar's No. 747

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child

Male

Twin
Triplet
or other?

(To be answered only in event of plural births)

{ and }

Number
in order
of birth

Legiti-
mate

yes

Date of
birth

June 2nd

1930

(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth. 1

(a) Born alive and now living 0

Born alive but now dead 0

Stillborn 0

FULL
NAME

Jessie Stewart England

FATHER

FULL
MAIDEN
NAME

Aritta Mitchell

MOTHER

Residence (Usual place of abode)

Pocatello Ida

Residence (Usual place of abode)

Pocatello

If non-resident, give place and State

If non-resident, give place and State

Color or race

White

Age at last Birthday

22

Color or race

White

Age at last Birthday

19

Birthplace

Idaho

(City and State or County)

Idaho

Birthplace

Idaho

(City and State or County)

Idaho

Occupation

Coach

Cleaner

R. B.

Occupation

House wife

House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

Born alive

Stillborn

at

10

M.

(Signature)

[Signature]

(Physician or midwife)

Address

Pocatello Idaho

Filed

July 1, 1930

Dr. J. H. Young

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECORDED COPY OF THIS DOCUMENT IS FILED IN THE OFFICE OF THE ATTORNEY GENERAL, DEPARTMENT OF JUSTICE, WASHINGTON, D.C. 20530

There were no outstanding physical
as the fact that the father purchased
the child with this money. I believe
that it was that matter which
caused the father to die.

on the date mentioned.

I hereby certify that I attended the birth of this child, who was [redacted] at [redacted] in [redacted] on the date mentioned.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

Name, occupation, address, and state of residence

Signature and date

Color of hair

It was stated on birth that

Birthplace (State and date)

Name

Station

Number of child at this birth

Sex

Weight

Length

Head

Birth

Signature

Date

Place

State

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 20431

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5832

(No. Lynn Brothers Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stewart Lee England(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX

Male

4. COLOR OR RACE

White5. Single, Married, Widowed,
or Divorced (write the word)Single

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) June 2, 1930.

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

000

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work.None(b) General nature of industry,
business, or establishment in
which employed (or employer)Infant

(c) Name of employer

None9. BIRTHPLACE (city or town)
(State or country)Pocatello,Idaho.

10. NAME OF FATHER

Jesse England11. BIRTHPLACE OF FATHER (city or town)
(State or Country)Moreland, Idaho.

12. MAIDEN NAME OF MOTHER

Aritta Mitchel13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)Ammon, Idaho.

14.

Informant Jesse England(Address) 335 North Sixth Ave. Poca., Ida.

15.

Filed 6/2/30., 19

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June2,1930

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 2, 1930 to June 2, 1930that I last saw him alive on June 2, 1930and that death occurred, on the date stated above, at 10.20 a.m.

The CAUSE OF DEATH* was as follows:

Blue Baby.

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?no

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

6/2/30., 19

(Address)

Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Ammon,Idaho.6/3/30. 19

20. Undertaker

Arthur W. Hall

Address

Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH JUL 3 1930
County of Blaine
City of Georgetown
No. 331-110004 244 St. _____
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. 25 State File No. 181899
(If born in hospital or institution give name.) Suebrook Prim. Registration District No. 213 Local Registrar's No. _____

FULL NAME OF CHILD _____
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>Jan 10 1930</u> (Month) (Day) (Year)
--------------------------	------------------------------	-----------	--------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth _____ (a) Born alive and now living 5

Born alive but now dead 4 Stillborn 1

FATHER FULL NAME <u>Harvin E. Clark</u>	MOTHER FULL MAIDEN NAME <u>Alice Fudge</u>
--	---

Residence (Usual place of abode) Georgetown Ida Residence (Usual place of abode) Georgetown Ida

Is non-resident, give address and State White If non-resident, give address and State White

Color or race White Age at last Birthday 39 Color or race White Age at last Birthday 38

Birthplace Utah (City and State or County) Birthplace Idaho (City and State or County)

Occupation Lawman Occupation Engineer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn Born alive at _____ M. on the date above stated.

(Signature) N. H. King

(Physician or midwife)

Address Montpelier Idaho

Filed 6/30/30 N. H. King Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

1. Name of child
 2. Date of birth
 3. Place of birth
 4. Name of mother
 5. Name of father
 6. Name of mother's maiden name
 7. Name of father's maiden name
 8. Name of child's present address
 9. Name of child's present school
 10. Name of child's present employer
 11. Name of child's present occupation
 12. Name of child's present religion
 13. Name of child's present political party
 14. Name of child's present social class
 15. Name of child's present race
 16. Name of child's present color
 17. Name of child's present sex
 18. Name of child's present age
 19. Name of child's present height
 20. Name of child's present weight
 21. Name of child's present eye color
 22. Name of child's present hair color
 23. Name of child's present skin color
 24. Name of child's present blood type
 25. Name of child's present fingerprints
 26. Name of child's present photographs
 27. Name of child's present X-rays
 28. Name of child's present medical records
 29. Name of child's present dental records
 30. Name of child's present psychological records
 31. Name of child's present psychiatric records
 32. Name of child's present criminal records
 33. Name of child's present civil records
 34. Name of child's present military records
 35. Name of child's present employment records
 36. Name of child's present education records
 37. Name of child's present social security records
 38. Name of child's present voter registration records
 39. Name of child's present passport records
 40. Name of child's present driver's license records
 41. Name of child's present marriage records
 42. Name of child's present divorce records
 43. Name of child's present death records
 44. Name of child's present burial records
 45. Name of child's present cremation records
 46. Name of child's present organ donation records
 47. Name of child's present cadaver donation records
 48. Name of child's present tissue donation records
 49. Name of child's present bone marrow donation records
 50. Name of child's present hair donation records
 51. Name of child's present skin donation records
 52. Name of child's present blood donation records
 53. Name of child's present plasma donation records
 54. Name of child's present platelet donation records
 55. Name of child's present stem cell donation records
 56. Name of child's present organ donation records
 57. Name of child's present bone donation records
 58. Name of child's present cornea donation records
 59. Name of child's present kidney donation records
 60. Name of child's present liver donation records
 61. Name of child's present heart donation records
 62. Name of child's present lung donation records
 63. Name of child's present pancreas donation records
 64. Name of child's present small intestine donation records
 65. Name of child's present large intestine donation records
 66. Name of child's present stomach donation records
 67. Name of child's present spleen donation records
 68. Name of child's present gallbladder donation records
 69. Name of child's present bladder donation records
 70. Name of child's present prostate donation records
 71. Name of child's present uterus donation records
 72. Name of child's present ovary donation records
 73. Name of child's present testis donation records
 74. Name of child's present epididymis donation records
 75. Name of child's present vas deferens donation records
 76. Name of child's present fallopian tube donation records
 77. Name of child's present uterine tube donation records
 78. Name of child's present cervix donation records
 79. Name of child's present vagina donation records
 80. Name of child's present penis donation records
 81. Name of child's present scrotum donation records
 82. Name of child's present foreskin donation records
 83. Name of child's present clitoris donation records
 84. Name of child's present labia donation records
 85. Name of child's present perineum donation records
 86. Name of child's present anus donation records
 87. Name of child's present rectum donation records
 88. Name of child's present sigmoid colon donation records
 89. Name of child's present descending colon donation records
 90. Name of child's present ascending colon donation records
 91. Name of child's present transverse colon donation records
 92. Name of child's present cecum donation records
 93. Name of child's present appendix donation records
 94. Name of child's present duodenum donation records
 95. Name of child's present jejunum donation records
 96. Name of child's present ileum donation records
 97. Name of child's present cecum donation records
 98. Name of child's present sigmoid colon donation records
 99. Name of child's present rectum donation records
 100. Name of child's present anus donation records

If there were no attending physician
 or dentist, then the child's health
 should be the responsibility of the
 child's mother or father. A child
 should be one year of age or older
 before being placed in the child's
 care.

(Signature)
 Address
 City
 State
 Zip
 Date
 Signature of mother
 Signature of father
 Signature of child
 Signature of physician
 Signature of dentist
 Signature of social worker
 Signature of teacher
 Signature of employer
 Signature of religious leader
 Signature of community leader
 Signature of other person
 Signature of child's present address
 Signature of child's present school
 Signature of child's present employer
 Signature of child's present occupation
 Signature of child's present religion
 Signature of child's present political party
 Signature of child's present social class
 Signature of child's present race
 Signature of child's present color
 Signature of child's present sex
 Signature of child's present age
 Signature of child's present height
 Signature of child's present weight
 Signature of child's present eye color
 Signature of child's present hair color
 Signature of child's present skin color
 Signature of child's present blood type
 Signature of child's present fingerprints
 Signature of child's present photographs
 Signature of child's present X-rays
 Signature of child's present medical records
 Signature of child's present dental records
 Signature of child's present psychological records
 Signature of child's present psychiatric records
 Signature of child's present criminal records
 Signature of child's present civil records
 Signature of child's present military records
 Signature of child's present employment records
 Signature of child's present education records
 Signature of child's present social security records
 Signature of child's present voter registration records
 Signature of child's present passport records
 Signature of child's present driver's license records
 Signature of child's present marriage records
 Signature of child's present divorce records
 Signature of child's present death records
 Signature of child's present burial records
 Signature of child's present cremation records
 Signature of child's present organ donation records
 Signature of child's present bone marrow donation records
 Signature of child's present hair donation records
 Signature of child's present skin donation records
 Signature of child's present blood donation records
 Signature of child's present plasma donation records
 Signature of child's present platelet donation records
 Signature of child's present stem cell donation records
 Signature of child's present organ donation records
 Signature of child's present bone donation records
 Signature of child's present cornea donation records
 Signature of child's present kidney donation records
 Signature of child's present liver donation records
 Signature of child's present heart donation records
 Signature of child's present lung donation records
 Signature of child's present pancreas donation records
 Signature of child's present small intestine donation records
 Signature of child's present large intestine donation records
 Signature of child's present stomach donation records
 Signature of child's present spleen donation records
 Signature of child's present gallbladder donation records
 Signature of child's present bladder donation records
 Signature of child's present prostate donation records
 Signature of child's present uterus donation records
 Signature of child's present ovary donation records
 Signature of child's present testis donation records
 Signature of child's present epididymis donation records
 Signature of child's present vas deferens donation records
 Signature of child's present fallopian tube donation records
 Signature of child's present uterine tube donation records
 Signature of child's present cervix donation records
 Signature of child's present vagina donation records
 Signature of child's present penis donation records
 Signature of child's present scrotum donation records
 Signature of child's present foreskin donation records
 Signature of child's present clitoris donation records
 Signature of child's present labia donation records
 Signature of child's present perineum donation records
 Signature of child's present anus donation records
 Signature of child's present rectum donation records
 Signature of child's present sigmoid colon donation records
 Signature of child's present descending colon donation records
 Signature of child's present ascending colon donation records
 Signature of child's present transverse colon donation records
 Signature of child's present cecum donation records
 Signature of child's present appendix donation records
 Signature of child's present duodenum donation records
 Signature of child's present jejunum donation records
 Signature of child's present ileum donation records
 Signature of child's present cecum donation records
 Signature of child's present sigmoid colon donation records
 Signature of child's present rectum donation records
 Signature of child's present anus donation records

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70350

PLACE OF DEATH
County of Bear Lake
City of Georgetown

Registration District No. 32
Primary Registration District No. 286

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)
(No.)

2. FULL NAME Baby Clark (Stillborn)
(a) Residence. No. Georgetown Idaho St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Infant
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Still - Born Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Georgetown Ida
10. NAME OF FATHER Marion E. Clark
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Georgetown Ida
12. MAIDEN NAME OF MOTHER Alice Budge
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Paris Ida

14. Informant M. E. Clark
(Address) Georgetown Ida
15. Filed 6/30/30 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 10 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 19 to 19 that I last saw him alive on 19 and that death occurred, on the date stated above, at m. The CAUSE OF DEATH was as follows: Instrument of Delivery of Mother (Still Born Child)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? ho
Did an operation precede death? ho Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. H. Hines M. D.
6/30/30 1930 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
19. Place of Burial, Cremation, or Removal Georgetown Ida Date of Burial Jan 11 1930
20. Undertaker Walter Clarke Address Georgetown Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile **Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS,** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED JUL 5 1930
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
COUNTY OF Blaine
CITY OF Montpelier
CERTIFICATE OF BIRTH
No. 963-208 964-294 St.
(If born in hospital or institution
give name.)
Registration District No. 57 State File No. 181928
Prim. Registration District No. 236 Local Registrar's No. S
FULL NAME OF CHILD (STILL BORN)

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>5-8</u> (Month) (Day) (Year) <u>1930</u>
----------------------------	---	-----	--------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? Yes

Number of child of this mother, including present birth one (a) Born alive and now living one

Born alive but now dead one Stillborn one

FULL NAME <u>C. W. FATHER</u>	FULL MAIDEN NAME <u>M. S. MOTHER</u>
----------------------------------	--

Residence (Usual place of abode) Blaine

If nonresident, give place and State

Color or race White Age at last Birthday 26 (Years)

Birthplace Blaine (City and State or Country)

Occupation John

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at Blaine M.
on the date above stated.

(Signature) W. B. Smith

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Montpelier, Ida

Filed 7/30/30 W. B. Smith Registrar.

RECEIVED JAN 30 1961

END OF LINE

1. The above information was obtained from a confidential source who has provided reliable information in the past.

10-11-64
(S)(u)(c)
10-11-64

What metaphoric was used to convey the following?

JUN 1968
MAY 1968

MINTA
SRA

[illegible]

(S) (U)

SECRET

100-443888-100

~~SECRET~~

SECRET

DECLASSIFIED BY: 6032
DATE: 10/10/2001

Address

1. The first part of the document is a header section containing the following information:

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70835

County of Ben Lue

City of Montpelier Idaho

Registration District No. 3

Primary Registration District No. 2136

Local Registrar's No. 206

(No. 1)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Robinson

(a) Residence. No. Montpelier Idaho St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Infant

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 5-8-30

7. AGE 1 Year 3 Months 30 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Still Born Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Montpelier Idaho
(State or country)

10. NAME OF FATHER Ed. Robinson

11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Matheson

13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant Ed Robinson
(Address) 6/30 Montpelier Idaho

15. Filed 6/30 1930 N. N. King Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 8 30
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5 1930, to 8 1930, that I last saw him alive on 5 1930, and that death occurred, on the date stated above, at 5 m. The CAUSE OF DEATH* was as follows:

cause not known
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Birth
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Birth

Did an operation precede death? No Date of 5/8/30

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) Dr. F. W. Baker, M. D.

5-7-30 (Address) Montpelier Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Montpelier Idaho Date of Burial May 10 1930

20. Undertaker F. M. Wilbur Address Montpelier Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of child stated.

PLACE OF BIRTH

RECEIVED JUL 7 1930
County of Bingham
City of Panguitch

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

SS

CERTIFICATE OF BIRTH

181961

No. 385-108-006-549 St.

Registration District No. 121 State File No.

(If born in hospital or institution give name.)

Prim. Registration District No. 2194 Local Registrar's No. 172

FULL NAME OF CHILD

Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u> and <u> </u> Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>June 8</u> 19 <u>30</u> (Month) (Day) (Year)
--------------------------	---	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth. 7 (a) Born alive and now living 6

Born alive but now dead. 1 Stillborn 2

FATHER FULL NAME <u>Floyd Thompson</u> Residence (Usual place of abode) <u>Panguitch</u> If non-resident, give place and State <u> </u> Color or race <u>White</u> Age at last Birthday <u>36</u> (Years) Birthplace <u>Utah Idaho</u> (City and State or County) Occupation <u>Farmer</u>	MOTHER FULL MAIDEN NAME <u>Edith Funniss</u> Residence (Usual place of abode) <u>Panguitch</u> If non-resident, give place and State <u> </u> Color or race <u>White</u> Age at last Birthday <u>33</u> (Years) Birthplace <u>Utah</u> (City and State or County) Occupation <u>Housewife</u>
---	--

FULL NAME Floyd Thompson FULL MAIDEN NAME Edith Funniss

Residence (Usual place of abode) Panguitch Residence (Usual place of abode) Panguitch

If non-resident, give place and State If non-resident, give place and State

Color or race White Age at last Birthday 36 (Years) Color or race White Age at last Birthday 33 (Years)

Birthplace Utah Idaho (City and State or County) Birthplace Utah (City and State or County)

Occupation Farmer Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 5:30 p M. on the (date above stated).

(Signature) C. W. Beck

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or)
Address Blackfoot, Idaho
Filed July 2, 1930 M. H. Hulse Registrar.

When there was no attending physician or midwife when the father was born, the child was born. A stillborn child is one that is born dead, not alive. When a child is born with a stillborn child, it is a stillborn child.

(Signature)

I hereby certify that I attended the birth of this child, who was born on the date stated.

(CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE)

(Signature)

(City and State of County)

(Date of Birth)

(Signature)

(City and State of County)

FATHER
NAME
MAYOR
FELL
CHILDREN

MOTHER

These provisions are used to prevent Optimalis management.

(Signature)

(Signature)

(Signature)

(Signature)

Registration Number

Prin. Registrar/Don District

(Signature)

(Signature)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70899

PLACE OF DEATH

County of Bingham

City of Pingree, Ida

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 704

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn Thompson

(a) Residence. No. Pingree, Idaho St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 8 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min. Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Pingree, Idaho (State or country)

10. NAME OF FATHER Floyd C. Thompson

11. BIRTHPLACE OF FATHER (city or town) Blackfoot (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Edith Furness

13. BIRTHPLACE OF MOTHER (city or town) Ogden (State or Country) Utah

14. Informant Floyd C. Thompson (Address) Pingree, Ida

15. Filed June 9, 1930 by Wm. M. Malone Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Stillborn June 8 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Had been dead about 4 days

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw h_____ alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted If not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. W. Beck M. D.

June 9, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pingree, Idaho Date of Burial June 4 1930

20. Undertaker None Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of Idaho RECEIVED JUL 5 1930
City of Boise
No. St.
856 209 007-393
(If born in hospital or institution
give name.)
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH **S 181999**
Registration District No. 57 State File No.
Prim. Registration District No. 2022 Local Registrar's No. 27
FULL NAME OF CHILD STILL BORN Heggefinger
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>7-9-30</u> (Month) (Day) (Year)
----------------------------------	---	---------------------------------------	--------------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 0 (a) Born alive and now living 0
Born alive but now dead 0 Stillborn 1 5 months

FATHER		MOTHER	
FULL NAME <u>Charles H. Heggefinger</u>	FULL MAIDEN NAME <u>Myrtle Fay Little</u>	Residence (Usual place of abode) <u>Boise, Idaho</u>	Residence (Usual place of abode) <u>Boise, Idaho</u>
If nonresident, give place and State	If nonresident, give place and State	Color or race <u>White</u>	Color or race <u>White</u>
Age at last Birthday <u>25</u> (Years)	Age at last Birthday <u>24</u> (Years)	Birthplace <u>Monroe, Iowa</u> (City and State or Country)	Birthplace <u>Boise, Idaho</u> (City and State or Country)
Occupation <u>Ranger</u>	Occupation <u>Home wife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 7450 M.
on the date above stated.

(Signature) Physician
(Physician or midwife)

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Address 1444 1st St
Filed 7-1 1930 Robert H Wright
Registrar

[illegible][illegible]

I have been asked to
make a check of the
...

10-11-68

(b)(7)(D) is not subject.

(continued)

SECRET

CONFIDENTIAL

14-00000

1950

RECEIVED
FEB 11 1970

1990年12月15日

with the most agile and

1946

~~CONFIDENTIAL~~

1990

10-10-68

[illegible]

ATTACHED

REF: BATTN 70 JAHN

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70904

PLACE OF DEATH

County of Blaine

City of Belleme

Registration District No. 57

Primary Registration District No. 2022

Local Registrar's No. 21

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, min. Still born 5 mos fetus

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Belleme, Idaho

10. NAME OF FATHER Charles H. Heffelfinger

11. BIRTHPLACE OF FATHER (city or town) (State or country) Idaho

12. MOTHER'S NAME OF MOTHER Myrtle Fay Little

13. BIRTHPLACE OF MOTHER (city or town) (State or country) Belleme, Idaho

14. Informant Mrs. Chas. Heffelfinger

(Address) Belleme, Idaho

15. Filled 7-1, 1930 P. H. Wright

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 9 1930

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 19, to, 19

that I last saw him alive on, 19

and that death occurred, on the date stated above, at, m.

The CAUSE OF DEATH* was as follows:

Still born 5 mos fetus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? E. W. Fox

(Signed) 6/10, 1930 (Address) Hailey, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Belleme, Idaho

6/10 1930

20. Undertaker

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonner
City of Grouse Creek, Ida

CERTIFICATE OF BIRTH

No. 954-109009 000 St. ---

Registration District No. 76

State File No. 182008

(If born in hospital or institution
give name.)

Prim. Registration District No. 2155

Local Registrar's No. 21

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>---</u>	and {	Number in order of birth <u>---</u>	Legiti- mate? <u>Yes</u>	Date of birth <u>6 9 1930</u>
(To be answered only in event of plural births)				(Month)	(Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? ---

Number of child of this mother, including present birth. --- (a) Born alive and now living 7

Born alive but now dead. --- Stillborn ---

FATHER
FULL NAME Edell Luman

MOTHER
FULL MAIDEN NAME Minnie

Residence (Usual place of abode) Grouse Creek Ida

Residence (Usual place of abode) Grouse Creek Ida

If non-resident, give place and State ---

If non-resident, give place and State ---

Color or race White Age at last Birthday 40
(Years)

Color or race White Age at last Birthday 37
(Years)

Birthplace Kansas
(City and State or County)

Birthplace Idaho
(City and State or County)

Occupation Laborer

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 5:30 P. M.
on the date above stated.

(Signature) Wm F. Tyler, M.D.

(Physician or midwife)

Address Sandpoint, Idaho

Filed June 3 1930 Idaho
Idaho

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71343

PLACE OF DEATH

County of Bonner

City of Grouse Creek, Ida. Registration District No. 76
Primary Registration District No. 2155

Local Registrar's No. 53

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn Druman

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 9, 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Grouse Creek
(State or country) Idaho

10. NAME OF FATHER Elmer Adell Druman

11. BIRTHPLACE OF FATHER (city or town) Kansas
(State or Country)

12. MAIDEN NAME OF MOTHER Minnie Bonney

13. BIRTHPLACE OF MOTHER (city or town) Wyoming
(State or Country)

14. Informant Elmer Adell Druman
(Address) Samuels, Idaho

15. Filed June 10, 1930 Viola Allen
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 9 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 9, 1930, to June 9, 1930
that I last saw him alive on stillborn, 1930

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Still birth 8 1/2 month
foetus cause unknown
(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. F. Tyler M. D.
June 10, 1930 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal
(I.O.F.)

Date of Burial
June 10 1930

20. Undertaker

Address

John + Geo. Bonney Sandpoint, Ida.
(mural)

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACED IN BIRTH JUL 10 1930

County of Bonneville
City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

182026

No. 251129 110-285 St.

Registration District No. 73 State File No.

(If born in hospital or institution
give name.)

Prim. Registration District No. 2100 Local Registrar's No. 239

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate?	Date of birth <u>4-29-1930</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------	------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol Sal 10%

Number of child of this mother, including present birth 4 (a) Born alive and now living 3

Born alive but now dead _____ Stillborn 1

FATHER

FULL NAME Mr. A. Beal

Residence (Usual place of abode) Idaho Falls

If nonresident, give place and State _____

Color or race White Age at last Birthday 29 (Years)

Birthplace Idaho Falls
(City and State or Country)

Occupation _____

MOTHER

FULL MAIDEN NAME Lucile Beal

Residence (Usual place of abode) Idaho Falls

If nonresident, give place and State _____

Color or race White Age at last Birthday 27 (Years)

Birthplace Idaho Falls
(City and State or Country)

Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 3:00 A. M. on the date above stated.

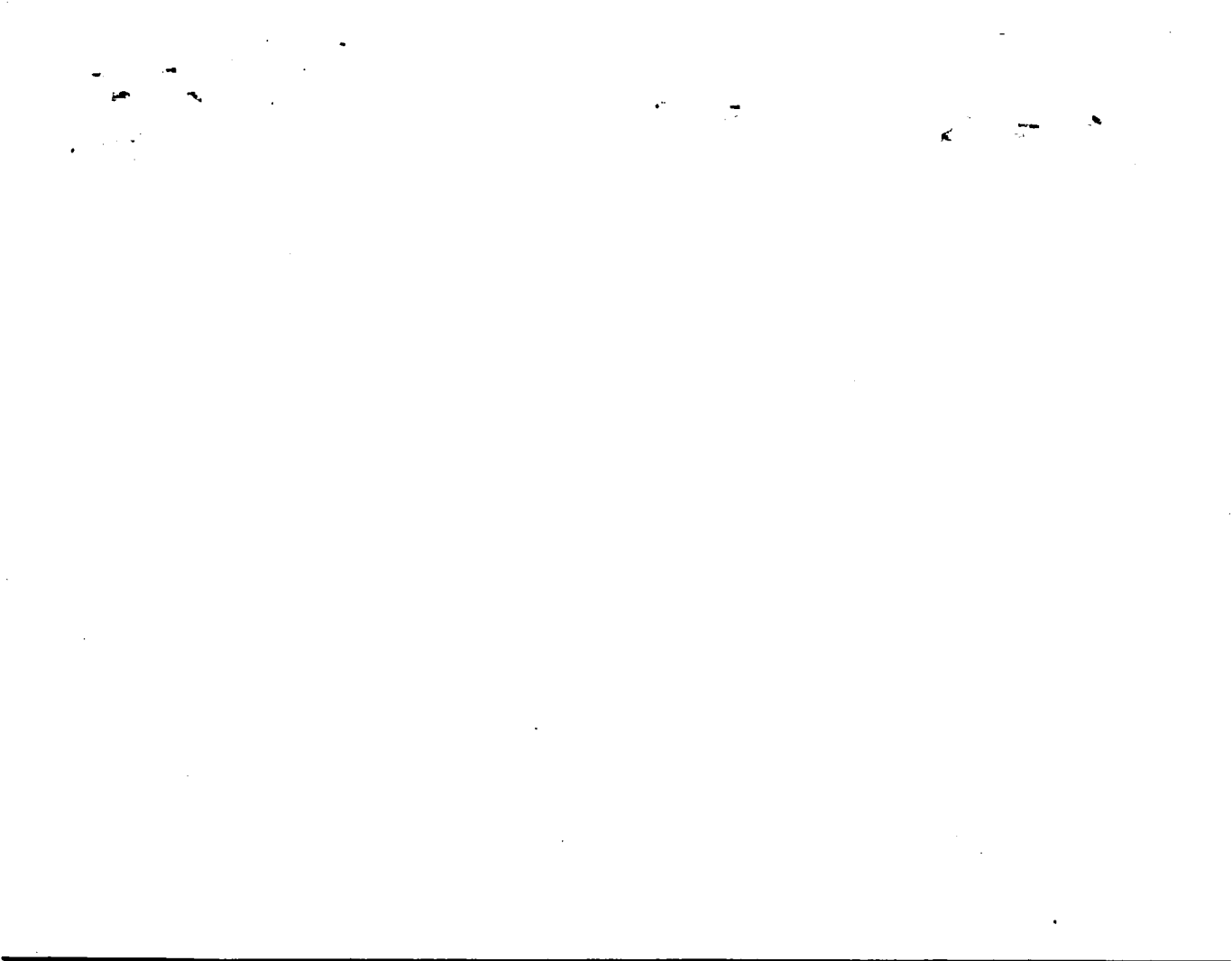
(Signature) [Signature]

(Physician or midwife)

Address Idaho Falls, Idaho

Filed 4-29-1930 [Signature]
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 40439

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bonerville Registration District No. 73
City of Idaho Falls R.R. #7 Primary Registration District No. 211-6

Local Registrar's No. 79

(If death occurred in a hospital or institution, give its name instead of street and number.)
2. FULL NAME (Still Born) Robert W. Beal

(a) Residence. No. 6 1/2 miles N on Montana Highway
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days
0 0 0
If LESS than 1 day, 0 hrs. or 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Idaho Falls
(State or country) Ida.

10 NAME OF FATHER W. A. Beal

11 BIRTHPLACE OF FATHER (city or town) Mo.
(State or country) Mathiam A Beal

12 MAIDEN NAME OF MOTHER Lucy Byerly

13 BIRTHPLACE OF MOTHER (city or town) Mo.
(State or country)

14 Informant Wm. A. Beal
(Address) Idaho Falls, Ida.

15 Filed Apr 24 19 30 Registrar V. F. M. Han

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
April 28 30
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Still Born to Still Born, 1930
that I last saw Still Born on Still Born, 1930

and that death occurred, on the date stated above, at Still Born m.

The CAUSE OF DEATH* was as follows:
Still Born. Premature

(duration) Went know yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) Went know yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. J. Sutton M. D.

4/28 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial

Idaho Falls Ida. 4/28 1930

20. Undertaker Address

V. F. M. Han Idaho Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonneville
City of Idaho Falls

CERTIFICATE OF BIRTH

No. _____ St. _____

296-116-010-233

Registration District No. 73

State File No. 182070

(If born in hospital or institution
give name.)

Prim. Registration District No. 210

Local Registrar's No. 260

FULL NAME OF CHILD "Stillbirth" Brothers

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child

Male

Twin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

June 16

1930

(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth. 3

(a) Born alive and now living. 1

Born alive but now dead 1

Stillborn 1

FATHER
FULL
NAME

Ben Brothers

MOTHER
FULL
MAIDEN
NAME

Emma Becker

Residence (Usual place of abode)

286, 15th St.

Residence (Usual place of abode)

286, 15th St.

If non-resident, give place and State

If non-resident, give place and State

Color or race

white

Age at last Birthday

44

Color or race

white

Age at last Birthday

25

Birthplace

Manassas Oklahoma

(City and State or County)

Birthplace

Merino, South Dakota

(City and State or County)

Occupation

Contractor

Occupation

House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 9:03 P. M.
on the date above stated.

(Signature)

(Physician or midwife)

Address

Idaho Falls

Filed

6/22

1930

C. J. Cunningham

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 3, 1862. It is a very long letter, and it contains a great deal of information about the state of the country at that time. It is a very important document, and it is one of the most interesting documents in the collection.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70944

PLACE OF DEATH

County of Bonneville
City of Idaho Falls, Ida

Registration District No. 23
Primary Registration District No. 217-0

Local Registrar's No. 28

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillbirth Brothers

(a) Residence. No. _____ St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Stillbirth</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year) <u>June 16, 1930</u>		
7. AGE	Years	Months
		Days
		If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		

9. BIRTHPLACE (city or town) Idaho Falls, Idaho
(State or country)

10. NAME OF FATHER

Ben Brothers

11. BIRTHPLACE OF FATHER (city or town)

Enid, Oklahoma
(State or Country)

12. MAIDEN NAME OF MOTHER

Emma Becker

13. BIRTHPLACE OF MOTHER (city or town)

Miner, South Dakota
(State or Country)

14.

Informant

(Address)

15.

Filed

6/111930E. J. West

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
June 16, 1930 to Jan 16, 1930
that I last saw him alive on June 16, 1930
and that death occurred, on the date stated above, at 8:30 P. M.
The CAUSE OF DEATH* was as follows:

Hemorrhage of mother

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

Placenta previa

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? Yes Date of 6/16/30Was there an autopsy? NoWhat test confirmed diagnosis? Operation(Signed) E. J. West, M. D.6/17, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Idaho Falls 6/18 1930

20. Undertaker

Address

V. F. M. Han Idaho Falls
Idaho

State

204

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of Lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

182088

County of Bonneville
City of Idaho Falls
No. 595-101-110-1373 St.

Registration District No. _____ State File No. _____

(If born in hospital or institution
give name.)

Local Registrar's No. 296

FULL NAME OF CHILD Still Birth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other?	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>July 1</u> (Month) (Day) (Year) <u>1930</u>
(To be answered only in event of plural births)					

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth. VII (a). Born alive and now living 4

Born alive but now dead 2 Stillborn 1

FULL NAME <u>Mr. J. Nielson</u>	FATHER	FULL MAIDEN NAME <u>Mary Williams</u>	MOTHER
------------------------------------	--------	---	--------

Residence (Usual place of abode) Idaho Falls Rt #3

If non-resident, give place and State _____

Color or race white Age at last Birthday 38

Birthplace Idaho (City and State or County) Idaho Falls (Years)

Occupation Farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 2 25 a. M.
on the date above stated.

(Signature) Dr. M. S. Williams

(Physician or midwife)

Address Idaho Falls

Filed June 20 1930 Williams

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Abstract

11

10/1/54

1990年12月

of the
in order
of the
to the

1. The following information is being furnished to you for your information:

6-13-68 10:15 AM

2000

100

— 10 —

[Illegible text]

CONFIDENTIAL - 4182 Dec 1952

NOTED BY [illegible]

100

1. 1941-1942

100-443887-100

[illegible]

TOP SECRET//SI//NF//NOFORN

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

[illegible]

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **71357**

PLACE OF DEATH

County of Bonneville CoCity of Isidore FallsRegistration District No. 73Primary Registration District No. 2140Local Registrar's No. 140

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillbirth(a) Residence. No. Isidore Falls R1 #3 St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. Single, Married, Widowed, or Divorced (write the word)

Baby

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

July 1, 1930

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

Isidore Falls Idaho

10. NAME OF FATHER

Wm J. Nielson

11. BIRTHPLACE OF FATHER (city or town) (State or country)

Hyrum Utah

12. MAIDEN NAME OF MOTHER

Mary Williams

13. BIRTHPLACE OF MOTHER (city or town) (State or country)

Isidore Falls R1 #3

14.

Informant

(Address)

Father Isidore Falls #3 R1

15.

Filed

7/9

19

30Idaho

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

July 1, 1930

17. I HEREBY CERTIFY, That I attended deceased from

July 1, 1930, to July 1, 1930that I last saw him alive on July 1, 1930and that death occurred, on the date stated above, at 2:35 P.M.

The CAUSE OF DEATH* was as follows:

Protopneus Cord.

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
If not at place of death?Did an operation precede death? Birth Date of July 1, 1930Was there an autopsy? NoWhat test confirmed diagnosis? Clinical

(Signed)

July 1, 1930 (Address) Isidore Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

July 1930

20. Undertaker

Address

J. A. Jones Isidore Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF RECEIVED JUN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonner
City of Idaho Falls

CERTIFICATE OF BIRTH

182102

No. 244729.010-251 St. _____

Registration District No. 73 State File No. _____

(If born in hospital or institution
give name.)

Prim. Registration District No. 2150 Local Registrar's No. 202

FULL NAME OF CHILD Prady Bumgarner (Stillborn)
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other?	and {	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>5-29-</u> 19 <u>30</u> (Month) (Day) (Year)
--------------------------	------------------------------	-------	--------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? Stillborn

Number of child of this mother, including present birth 12 (a) Born alive and now living none

Born alive but now dead one Stillborn yes - one - none

FATHER FULL NAME <u>Lawrence H. Bumgarner</u>	MOTHER FULL NAME <u>Annie May Beasley</u>
--	--

Residence (Usual place of abode) Shelley Idaho

If non-resident, give place and state _____

Color or race white Age at last Birthday 22 (Years)

Birthplace Blackfoot Idaho (City and State or County)

Occupation Plumber

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 7:36 P.M.
on the date above stated.

(Signature) Edwin Curtis M.D.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

(Physician or midwife)
Address Shelley Idaho
Filed May 29 1930 Curtis

STATE OF IDAHO
 DEPARTMENT OF PUBLIC SAFETY
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

Registration District No. _____ State File No. _____
 Primary Registration District No. _____
 FULL NAME OF CHILD _____
 (If child born in Idaho)
 Date of Birth _____
 Place of Birth _____
 Sex _____
 Color _____
 Height _____
 Weight _____
 (To be completed only in case of birth in Idaho)

What hospital or place was used to procure Optimum? _____
 Name of child of this mother including present date _____
 Date alive and now living _____
 (A) Born alive and now living _____
 (B) Born alive and now dead _____
 (C) Stillborn _____
 (D) Fetus _____
 (E) Embryo _____
 (F) Other _____

Place of birth _____
 Color of hair _____
 Color of eyes _____
 Occupation _____
 (If child born in Idaho)
 Date of birth _____
 Place of birth _____
 Sex _____
 Color _____
 Height _____
 Weight _____
 (To be completed only in case of birth in Idaho)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who was born on the _____ day of _____, 19____, at _____, Idaho.
 (Signature) _____

It is hereby certified that no attending physician or midwife was present at the birth of this child, who was born on the _____ day of _____, 19____, at _____, Idaho.
 (Signature) _____

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD AS KEPT IN THE OFFICE OF THE DEPARTMENT OF PUBLIC SAFETY, BUREAU OF VITAL STATISTICS, AT BOISE, IDAHO.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70954

PLACE OF DEATH

County of Bonanza
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 214-2

Local Registrar's No. 110

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Burr Garner

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Still born

5a. If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6. DATE OF BIRTH (month, day and year)

7. AGE Still born
Years _____ Months _____ Days _____
If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Still born
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls
(State or country)

10. NAME OF FATHER Lawrence Burr Garner

11. BIRTHPLACE OF FATHER (city or town) Blackfoot, Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Annie May Beasley

13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant Mary Beasley
(Address) Shelley, Idaho

15. Filed May 29, 1930 E. J. G. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Unknown
(Month) _____ (Day) _____ (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from 5-29-1930, to 5-29-1930
that I last saw him alive on _____, 19

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Nephritis of Mother.

(duration) _____ yrs. _____ mos. 14 ds.

CONTRIBUTORY Pregnancy
(Secondary) (duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted at home
if not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Substantive

(Signed) Edwin C. Custer, M. D.

5-29-1930 (Address) Shelley, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shelley Cemetery
Date of Burial 5-29-1930

20. Undertaker none
Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

249-221010-466
PLACE OF BIRTH

County of Sanneville
City of Idaho Falls, Ida.

JUN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

No. _____ St. _____

L.D.S. Hospital

(If born in hospital or institution give name.)

Registration District No. 73 State File No. 182110

Prim. Registration District No. 2 Local Registrar's No. 199

FULL NAME OF CHILD Baby Smith

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate?	Date of birth <u>may 21 1930</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 6 (a) Born alive and now living 4

Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME Ben Franklin Smith

Residence (Usual place of abode) Ririe

If nonresident, give place and State

Color or race white Age at last Birthday 37
(Years)

Birthplace Cedar City, Utah
(City and State or Country)

Occupation farmer

MOTHER
FULL MAIDEN NAME Larrah Moore

Residence (Usual place of abode) Ririe

If nonresident, give place and State

Color or race white Age at last Birthday 36
(Years)

Birthplace Shelton, Idaho
(City and State or Country)

Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 6:40 M.
on the date above stated.

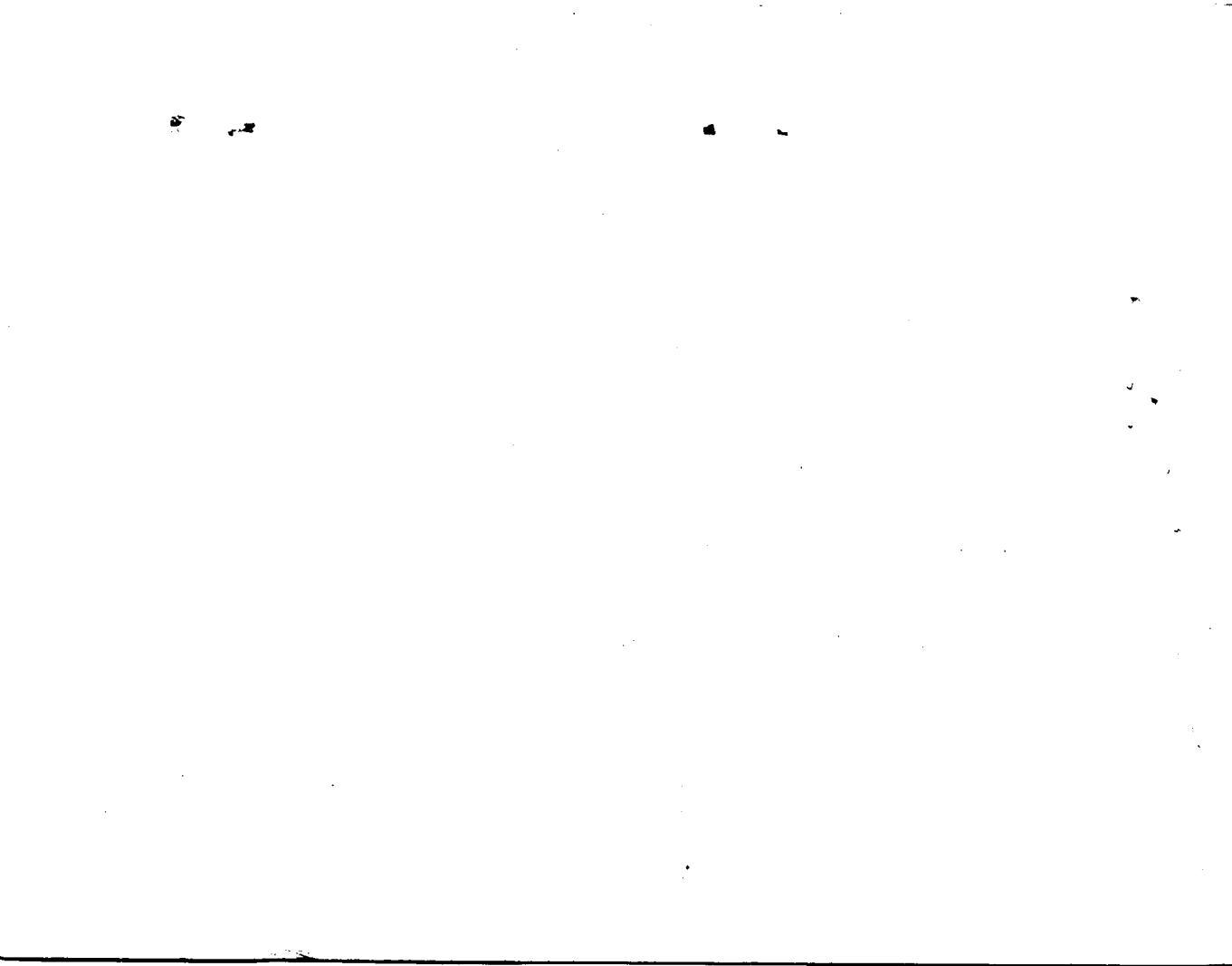
(Signature) Ray Hatch M.D.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address Idaho Falls, Idaho

Filed May 22 1930 C. J. [Signature]
Registrar.



RECEIVED JUN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70926

PLACE OF DEATH

County of Bonneville

City of Idaho Falls, Ida

Registration District No. 23

Primary Registration District No. 2100

(No. L.D.S. Hospital)

Local Registrar's No. 106

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Smith

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word)

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 21, 1930

7. AGE Years Months Days IF LESS than 1 day, hrs. or min. Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls, Idaho (State or country)

10. NAME OF FATHER Ben Franklin Smith

11. BIRTHPLACE OF FATHER (city or town) Cedar City, Utah (State or Country)

12. MAIDEN NAME OF MOTHER Sarah Moore

13. BIRTHPLACE OF MOTHER (city or town) Shelton, Idaho (State or Country)

14. Informant B. F. Smith (Address) Rivie Idaho

15. File 1422, 1930 Dec 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 21, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 19, to , 19

that I last saw him alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Stillborn - 6 mo. premature

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Ray Hatch, M. D.

, 19, Address) Salt Lake

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Cremation 12/22/30

20. Undertaker Address

Registrar

MARGIN RESERVED FOR BINDER

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

182110 +

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

267906 Oro 265

PLACE OF BIRTH

RECEIVED

JUN 20 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Bonneville
City of Idaho Falls

CERTIFICATE OF BIRTH

182134

No. _____ St. _____

L.S. Hospital
(If born in hospital or institution
give name.)

Registration District No. 73 State File No. _____

Prim. Registration District No. 2100 Local Registrar's No. 181

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other?	{ and }	Number in order of birth	Legiti- mate? <u>yo</u>	Date of birth <u>April 6</u> 19 <u>30</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 7 (a) Born alive and now living 6

Born alive but now dead _____ Stillborn 1

FATHER		MOTHER	
FULL NAME <u>Mr. Philip C. Borreson</u>	FULL MAIDEN NAME <u>Annie Marie Snerson</u>		
Residence (Usual place of abode) <u>St. Anthony</u>	Residence (Usual place of abode) <u>St. Anthony Idaho</u>		
If non-resident, give place and State _____	If non-resident, give place and State _____		
Color or race <u>white</u> Age at last Birthday <u>43</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>40</u> (Years)		
Birthplace <u>Spring City Utah</u> (City and State or County)	Birthplace <u>Mount Pleasant Utah</u> (City and State or County)		
Occupation <u>Farmer</u>	Occupation <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 5:45 P.M. on the date above stated.

(Signature) W. C. O'Brien M.D.

Physician & Surgeon
(Physician or midwife)

Address Idaho Falls Idaho

Filed May 10 1930 C. J. ...
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

182134 +

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 1001

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73

Primary Registration District No. 214-0

Local Registrar's No. 96

(If death occurred in a hospital or institution, give its name instead of street and number.)
L.D.S. Hospital

2. FULL NAME Stillborn

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years

Months

Days

If LESS than 1 day,
hrs. or
min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls
(State or country)

10. NAME OF FATHER

Phillip C. Borresen

11. BIRTHPLACE OF FATHER (city or town) Spring City
(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Annie Christie Swensen

13. BIRTHPLACE OF MOTHER (city or town) Mount Pleasant
(State or Country) Utah

14. Informant

(Address) L.D.S. Hospital
Idaho Falls Idaho

15. Filed

May 12, 1930

Stillborn

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April

(Month)

6

(Day)

1930

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 6, 1930, to Apr 6, 1930

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

Perinatal birth

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

d.

(duration)

yrs.

mos.

d.

18. Where was disease contracted if not at place of death? St. Luke's

Did an operation precede death? Yes

Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Dr. C. C. C.

M. I.

19. (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

19

20. Undertaker

Address

none

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

396-117 010-289

RECEIVED JUN 20 1930
County of Bonneville
City of Shales Falls, Idaho

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

No. _____ St. _____
L.O.S. Hospital

CERTIFICATE OF BIRTH
Registration District No. 73 State File No. 182142

(If born in hospital or institution give name.)

Prim. Registration District No. 214 Local Registrar's No. 192

FULL NAME OF CHILD Jennett Smith Croft
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	Number in order of birth { and }	Legiti- mate? <u>yes</u>	Date of birth <u>May 17</u> 19 <u>30</u> (Month) (Day) (Year)
-----------------------------	---	---	--------------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth. 4 (a) Born alive and now living. 2

Born alive but now dead. 1 Stillborn 1

FATHER
FULL NAME Frank Croft

MOTHER
FULL MAIDEN NAME Jennett Smith

Residence (Usual place of abode) 266 Second St.

Residence (Usual place of abode) 266 Second Street

If non-resident, give place and State _____

If non-resident, give place and State _____

Color or race white Age at last Birthday 28 (Years)

Color or race white Age at last Birthday 27 (Years)

Birthplace Built Idaho
(City and State or County)

Birthplace Reynolds Idaho
(City and State or County)

Occupation Bookman

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 10:30 A.M. on the date above stated.

(Signature) [Signature]

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Shales Falls Idaho

Filed May 17 1930 Registrar.

STATE OF NEW YORK
IN SENATE
JANUARY 17, 1915

(RECEIVED)

Honorable Members of the Senate,
Respectfully submitted,

(It will be noted that the bill is now in the hands of the committee.)

Very truly,
Yours,
[Signature]

Very truly,
Yours,
[Signature]

That committee was held in session on January 17, 1915.

It was held in session on January 17, 1915.

Very truly,
Yours,
[Signature]

Honorable Members of the Senate,
Respectfully submitted,

Very truly,
Yours,
[Signature]

Honorable Members of the Senate,
Respectfully submitted,

Very truly,
Yours,
[Signature]

Honorable Members of the Senate,
Respectfully submitted,

Very truly,
Yours,
[Signature]

Honorable Members of the Senate,
Respectfully submitted,

Very truly,
Yours,
[Signature]

Honorable Members of the Senate,
Respectfully submitted,

Very truly,
Yours,
[Signature]

Honorable Members of the Senate,
Respectfully submitted,

STATE OF NEW YORK
IN SENATE
JANUARY 17, 1915
RECEIVED
HONORABLE MEMBERS OF THE SENATE
RESPECTFULLY SUBMITTED
VERY TRULY,
YOURS,
[Signature]

MARGIN RESERVED FOR BINDING

182142

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. NO. 9-25 M-1-10

REGISTERED

JUN 20 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bonneville Registration District No. 73
City of Shoshone Falls, Ida Primary Registration District No. 214-0
(No. _____ St.)

State File No. 70922
Local Registrar's No. 102

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Croft

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word)

6. DATE OF BIRTH may 17 1930
(Month) (Day) (Year)

7. AGE stillborn IF LESS than 1 day how many
Yrs. Mos. ds. hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho Falls, Idaho

10. NAME OF FATHER Frank Croft

11. BIRTHPLACE OF FATHER (State or Country) Basalt, Idaho

12. MAIDEN NAME OF MOTHER Jeannette Smith

13. BIRTHPLACE OF MOTHER (State or Country) Rexburg, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. C. Croft
(Address) Shoshone Falls, Ida

15. Filed May 18 1930 Jeannette Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH may 17 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19,
that I last saw him alive on 19,
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Stillborn birth

(Duration) yrs. mos. ds.
Contributory I don't know
(Secondary)
(Signed) Dr. C. C. Croft M. D.
19 (Address) Shoshone Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Shoshone Falls, Ida DATE OF BURIAL May 17 1930

20. UNDERTAKER None ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

RECEIVED JUL 29 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho

JUL 24 1930

Mrs. F. Croft
Idaho Falls

182142
BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD

Jemmett Smith Croft.

PLACE OF
BIRTH

Idaho Falls

DATE OF
BIRTH

May 17, 1930

SEX OF
CHILD

Male

1. Number of children born to this mother, including present birth 5
2. Number born alive and now living 2
3. Born alive but now dead 1
4. Number of children stillborn 2

(Please write plainly)

Information with reference to

FATHER

Francis Jemmett Croft.
(Full name)

Idaho Falls Idaho.
(Residence)

Age at last birthday 27

Basalt Idaho
(Birthplace)

C. S. L. Brokeman
(Occupation)

Information with reference to

MOTHER

Juanita Williams
(Full maiden name)

Idaho Falls Idaho
(Residence)

Age at last birthday 27

Rexburg Idaho
(Birthplace)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C. K. Macey

C.K. Macey
Special Agent, Bureau of the Census.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED JUL 5 1920

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

County of Canyon
City of Nampa
No. 85 St. 595-204 014 139
(If born in hospital or institution give name.)

Registration District No. 7 State File No. 182164
Prim. Registration District No. 2006 Local Registrar's No. 130

FULL NAME OF CHILD Fay Lee Vincent
(If stillborn, substitute the word "Stillborn" for name of child)

Sex of Child Female Twin Triplet or other Tw and { Number in order of birth 2 } Legitimate Yes Date of birth 6-4 1920
(To be answered only in event of plural births) (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol 10%

Number of child of this mother, including present birth 10 (a) Born alive and now living 9
Born alive but now dead none Stillborn one

FATHER	MOTHER
FULL NAME <u>Orithan Franklin Vincent</u>	FULL MAIDEN NAME <u>Julia Frances Ocre</u>
Residence (Usual place of abode) <u>Nampa R5</u>	Residence (Usual place of abode) <u>Nampa R5</u>
If nonresident, give place and State	If nonresident, give place and State
Color or race <u>White</u> Age at last Birthday <u>57</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>37</u> (Years)
Birthplace <u>Yazoo Co. Ark.</u> (City and State or Country)	Birthplace <u>Calhoun Co. Tex.</u> (City and State or Country)
Occupation <u>laborer</u>	Occupation <u>housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 9: A. M.
on the date above stated.

(Signature) J. C. Horton

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife) R. D.
Address Nampa Ida.
Filed 0-3 1920 in the main
Registrar.

1

2

3

4

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70970

PLACE OF DEATH

County of Canyon
City of Rural

Registration District No. 2
Primary Registration District No. 2006

Local Registrar's No. 22

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. 7 1/2 miles E. ofampa

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4. COLOR OR RACE

5. Single, married, widowed, or Divorced (write the word)

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)14. Informant
(Address)

15. Filed

1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1930
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

6-4-30, 1930, to

that I last saw her alive on

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Still born Due to
Shoulder presentation.
(duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) J. C. Horton, M. D.6-26-30 (Address) ampa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

St. Mary's Cem 6-5-30

20. Undertaker F. W. Robison

Address

ampa
ampa Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

386 101022 253

PLACED **RECEIVED** JUN 23 1930

County of Jerome

City of Jerome

No. St.

St. Valentine Hospital

(If born in hospital or institution
give name.)

Registration District No. 18

State File No. 182872

Prim. Registration District No. Jerome

Local Registrar's No. Jerome

FULL NAME OF CHILD Erwin Dewey Thomason Jr.

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child

male

Twin

Other 2

and { Number
in order
of birth

(To be answered only in event of plural births) 2

Legiti-
mate?

yes

Date of
birth

April 1

1930

(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth. 2

(a) Born alive and now living 1

Born alive but now dead.

Stillborn 1

FATHER
FULL
NAME

George Dewey Thomason

MOTHER
FULL
MAIDEN
NAME

Leona L. Kelly

Residence (Usual place of abode)

Jerome Idaho

Residence (Usual place of abode)

Jerome Idaho

If non-resident, give place and State

If non-resident, give place and State

Color or race

white

Age at last Birthday

31

(Years)

Color or race

white

Age at last Birthday

31

(Years)

Birthplace

Ark

(City and State or County)

Birthplace

Ark

(City and State or County)

Occupation

Farmer

Occupation

House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was

Born alive

Stillborn

at 9 00 A. M.

on the date above stated.

(Signature)

Chas. H. Zeller

(Physician or midwife)

Address

Jerome Idaho

Filed

4/2

1930

Chas. H. Zeller

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

and with a view to the
of a child in
to at once to a
and that a
and that a

Address

First

I hereby certify that I attended the birth of this child who was
the date stated.

STATE OF ATTENDING PHYSICIAN OR MIDWIFE

Signature

Address

City and State of

County of

State of

County of

City and State of

County of

State of

County of

City and State of

County of

State of

County of

City and State of

County of

State of

County of

City and State of

County of

State of

County of

City and State of

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

182572-N

RECEIVED JUN 23 1930
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71066

County of Jerome

City of Drum

Registration District No. 78

Primary Registration District No. _____

Local Registrar's No. _____

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dewey Jr. Thomason

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____

6. DATE OF BIRTH (month, day and year) Apr 1, 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Idaho
(State or country)

10. NAME OF FATHER Dewey Thomason

11. BIRTHPLACE OF FATHER (city or town) Arkansas
(State or Country)

12. MAIDEN NAME OF MOTHER Lerna Kelly

13. BIRTHPLACE OF MOTHER (city or town) Arkansas
(State or Country)

14. Informant Dewey Thomason
(Address)

15. Filed 4/1, 1930 Chas F Zeller
Registrar

16. DATE OF DEATH April 1st 1930
Month Day Year

17. I HEREBY CERTIFY, That I attended deceased from April 1st, 1930, to April 1st, 1930

that I last saw h _____ alive on _____, 19 _____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still Born Infant
(Turn) Torsion Cord Intra-uterine

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) C. F. Zeller M. D.

4/23, 1930 (Address) Jerome, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Jerome Idaho Date of Burial Apr 2 1930

20. Undertaker none Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF RECEIPT JUL 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Latah
City of Moscow

No. 693-123029-216 St.

(If born in hospital or institution
give name.)

CERTIFICATE OF BIRTH

182436

Registration District No. 61 State File No. 58

Prim. Registration District No. 1011 Local Registrar's No. 58

FULL NAME OF CHILD

Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>June 23</u> 19 <u>30</u> (Month) (Day) (Year)
--------------------------	-----------------------------------	-----------------------------------	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth. 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>Victor Nilsson</u>	MOTHER FULL MAIDEN NAME <u>Pearl Dorothy Sawyer</u>
---	--

Residence (Usual place of abode) Moscow Idaho

If non-resident, give place and State

Color or race White Age at last Birthday 24 (Years)

Birthplace Washington (City and State or County)

Occupation Librarian

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 12:15 P. M. on the date above stated.

(Signature) C. J. Armstrong

(Physician or midwife)

Address Moscow Idaho

Filed July 9 1930 W. H. Linhart Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Where there was no attending physician at birth, then the father, mother, or other person should make this return. It should be signed by the person making the return. This is one that neither parent nor grandparent should sign.

I hereby certify that I am the birth of this child who was born at

St. Louis

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

Registration

(City and State of Missouri)

(Name)

Order on Birth

Residence (Last place of abode)

There after was born

St. Louis

Number of child of this mother to whom account is due

What previously was used in previous Certificate of Birth

Child

Legal

Date of

Full Name of Child

Registration District No. 11

Registration District No. 11

CERTIFICATE OF BIRTH

DEPARTMENT OF HEALTH

1914

RECEIVED JUL 12 1930

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61

County of

Primary Registration District No. 1011

City of

(No. St.)

File No. 71106Registered No. 36

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

..... yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Victor Wilson

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Pearl Dorothy Sawyer

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

July 9

1930

J. H. E. E. E.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

191

(Year)

I HEREBY CERTIFY, That I attended deceased from
June 23 19130 to June 23 19130
that I last saw h. ✓ alive on 19130

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn -
Premature

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

19

(Address)

Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

182436 *

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

66 6010-029-693

PLACE OF BIRTH

RECEIVED JUN 23 1930

County of Blaine
City of Moscow
No. 62570 St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 61 State File No. 182457

(If born in hospital or institution
give name.)

Prim. Registration District No. 1011 Local Registrar's No. 39

FULL NAME OF CHILD Premature 4 months Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Undetermined</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth (Month) (Day) (Year) <u>May 10, 1930</u>
-------------------------------------	---	-----	--------------------------------	--------------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? ✓

Number of child of this mother, including present birth 3 (a) Born alive and now living 1

Born alive but now dead 1 Stillborn 1

FATHER FULL NAME <u>Frank H. Woolf</u>	MOTHER FULL MAIDEN NAME <u>Helen Williams</u>
---	--

Residence (Usual place of abode) <u>Moscow Idaho</u>	Residence (Usual place of abode) <u>Moscow Idaho</u>
--	--

If non-resident, give place and State	If non-resident, give place and State
---------------------------------------	---------------------------------------

Color or race <u>White</u> Age at last Birthday <u>29</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>22</u> (Years)
---	---

Birthplace <u>Canada</u> (City and State or County)	Birthplace <u>Idaho</u> (City and State or County)
---	--

Occupation <u>Laborer</u>	Occupation <u>Housewife</u>
---------------------------	-----------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 2:30 P. M.
on the date above stated.

(Signature) Chas. E. Gutman

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address Moscow Idaho

Filed 6/19 1930 E. Kaufman

Registrar.

CHANG
UP TO
OF THE
THE
THE

Registration Office
The Registration Office

11. With the following information

Local
Date
Add. in case
of birth

With the following information

Number of children born

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

314-006-035-719
PLACE OF BIRTH
RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 182549

No. _____ St.

Registration District No. 96 State File No.

(If born in hospital or institution give name)

Prim. Registration District No. 1009 Local Registrar's No.

FULL NAME OF CHILD

Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child

✓

Twin
Triplet
or other?

and { Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

(Month)

(Day)

19. 30
(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 0 (a) Born alive and now living 0

Born alive but now dead

Stillborn 1 ✓

FATHER
FULL NAME Lester L. Campbell

MOTHER
FULL MAIDEN NAME Francis Parsons

Residence (Usual place of abode) Lewiston

Residence (Usual place of abode) Lewiston

If nonresident, give place and State

If nonresident, give place and State

Color or race Wht Age at last Birthday 19 (Years)

Color or race Wht Age at last Birthday 19 (Years)

Birthplace Wt (City and State or Country)

Birthplace Wash (City and State or Country)

Occupation Fisherman

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 4:25 M.
on the date above stated. { Stillborn }

(Signature) O. C. Carson
Lewiston, Ida
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address _____
Filed 7-7-30 J. M. Lytle
Registrar.

2

4

4.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No.

PLACE OF DEATH

County of Blaine
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Leon G. Campbell

(a) Residence. No. 157- 7th Street St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 5/6/30

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Premature

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston Idaho
(State or country)

10. NAME OF FATHER Lester Campbell

11. BIRTHPLACE OF FATHER (city or town) Wash
(State or Country)

12. MAIDEN NAME OF MOTHER Francis Parsons

13. BIRTHPLACE OF MOTHER (city or town) Wash.
(State or Country)

14. Informant Lester Campbell
(Address) Lewiston Idaho

15. Filed Jan 1, 1930 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 6 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6, 1930, to May 6, 1930
that I last saw him alive on May 6, 1930
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Premature birth
(duration) yrs. mos. ds.

CONTRIBUTORY Secondary
(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical finding

(Signed) S. E. Carson, M. D.

1/1, 1930 (Address) Lewiston Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Halla Halla Hag Date of Burial 5/9 1930

20. Undertaker Wasson Mortuaries Address Lewiston Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

265 222-035 296
PLACE OF BIRTH

RECEIVED JUL 14 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

County of Mayhew
City of Levinston, ColoradoNo. _____ St. _____ Registration District No. 96 File No. 182572Hospital _____ Primary Registration District No. 009 Registered No. _____

FULL NAME OF CHILD

Virginia Sweet

(Certificate of no value without full name of child.)

Sex of Child <u>7</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>4-22-</u> (Month) (Day) (Year) <u>1930</u>
-----------------------	---	---	-----------------------------	---

What bactericidal solution was used in eyes? _____

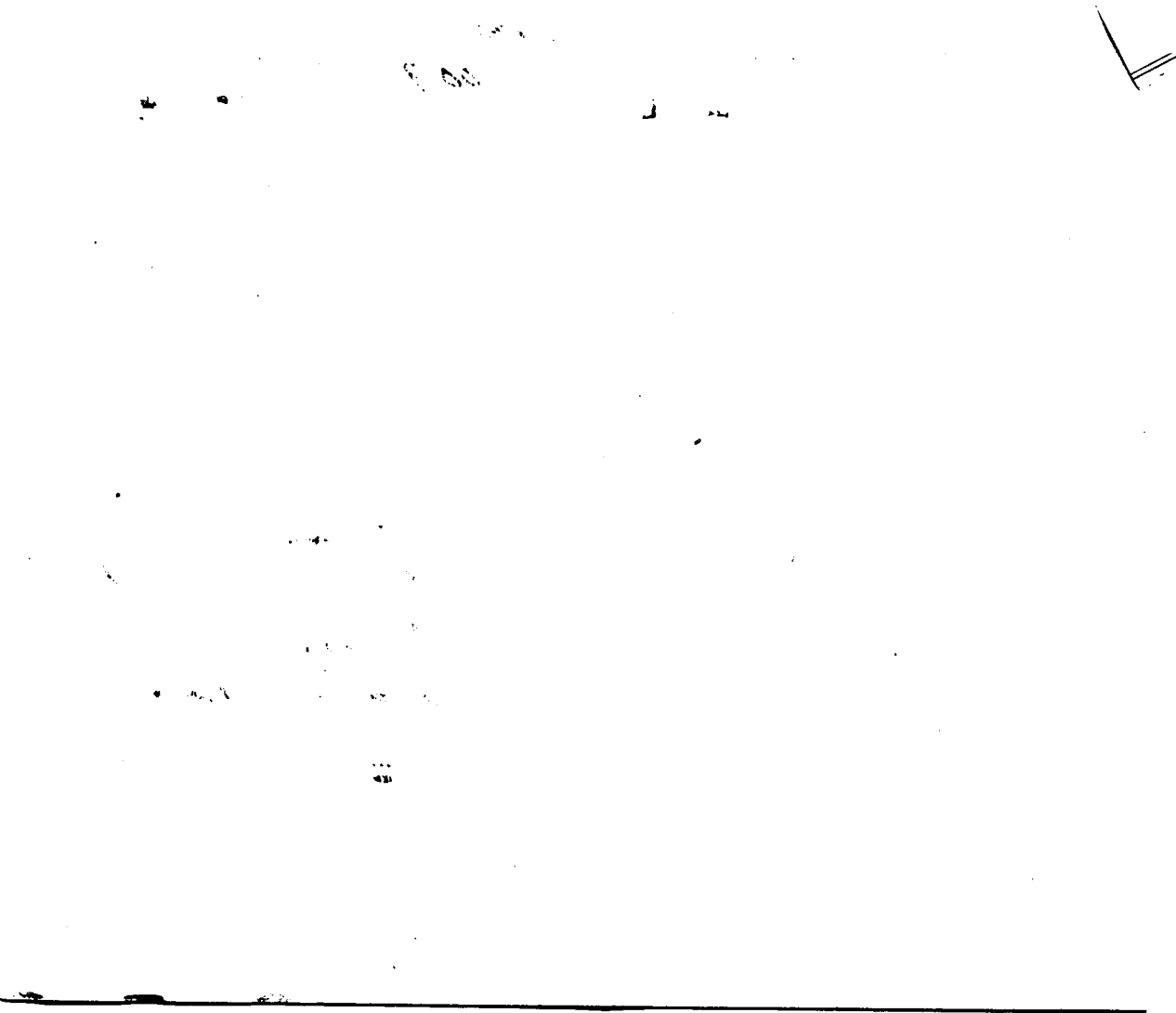
Number of child of this mother, including present birth. 4 Number of children of this mother now living, including present birth. 2FULL NAME FATHER Harold SweetFULL MAIDEN NAME MOTHER Issie BrownRESIDENCE Levinston, Colorado, Ida.RESIDENCE Levinston, Colorado, Ida.COLOR W AGE AT LAST BIRTHDAY 30
(Years)COLOR W AGE AT LAST BIRTHDAY 30
(Years)BIRTHPLACE WashingtonBIRTHPLACE OklahomaOCCUPATION LabourerOCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born at 1230 p M.
on the date above stated. (Dead or stillborn)*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.(Signature) W. H. House M.D.

Give names added from a supplemental report.

(Physician or midwife)
Address Levinston, IdahoFiled 7-10-30 1930 M. Lyle
Registrar. Registrar.



RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. *1009*

-PLACE OF DEATH

County of Nez PerceCity of LewistonRegistration District No. *2586*Primary Registration District No. *1009*Local Registrar's No. *206* ✓(No. *1009*)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Virginia Sweet(a) Residence. No. *St.*

(Usual place of abode)

Orchards

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) April 22nd, 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston, I
(State or country) Idaho10. NAME OF FATHER H. R. Sweet11. BIRTHPLACE OF FATHER (city or town) Seattle
(State or Country) Washington12. MAIDEN NAME OF MOTHER Leslie Mae Brown13. BIRTHPLACE OF MOTHER (city or town) Oklahoma
(State or Country)14. Informant W. R. Sweet
(Address) Lewiston, Idaho15. Filed Jan 1, 1930 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 22nd, 1930 19 *20*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

4/22-30, 19 *20*, to 4/22-30, 19 *20*that I last saw him alive on _____, 19 *20*

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
If not at place of death?Did an operation precede death? No Date of _____Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. R. Sweet, M. D.4/23/30, 19 *20* (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Lewiston, Idaho 4/23/30 19 *20*

20. Undertaker Address

Brower-Wann Company Lewiston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

182572 A

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

445 124 035 261

PLACE OF BIRTH

RECEIVED JUL 14 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Nez PerceCity of Lewiston

CERTIFICATE OF BIRTH

No. _____ St. _____

Registration District No. 96File No. 182573

Hospital _____

Primary Registration District No. 1009

Registered No. _____

FULL NAME OF CHILD

Boby Mundell

(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other? _____ { and { Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>4-24-30</u>	192__
	(To be answered only in event of plural births)		(Month) (Day) (Year)	

What bactericidal solution was used in eyes? 20% ArgrolNumber of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0FULL NAME FATHER Leo E. MundellFULL MAIDEN NAME MOTHER Verna SwartzRESIDENCE Lewiston, Ida.RESIDENCE Lewiston, Ida.COLOR W AGE AT LAST BIRTHDAY 22 (Years)COLOR W AGE AT LAST BIRTHDAY 18 (Years)BIRTHPLACE Colo.BIRTHPLACE Colo.OCCUPATION SalesmanOCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____ at _____ M. on the date above stated.

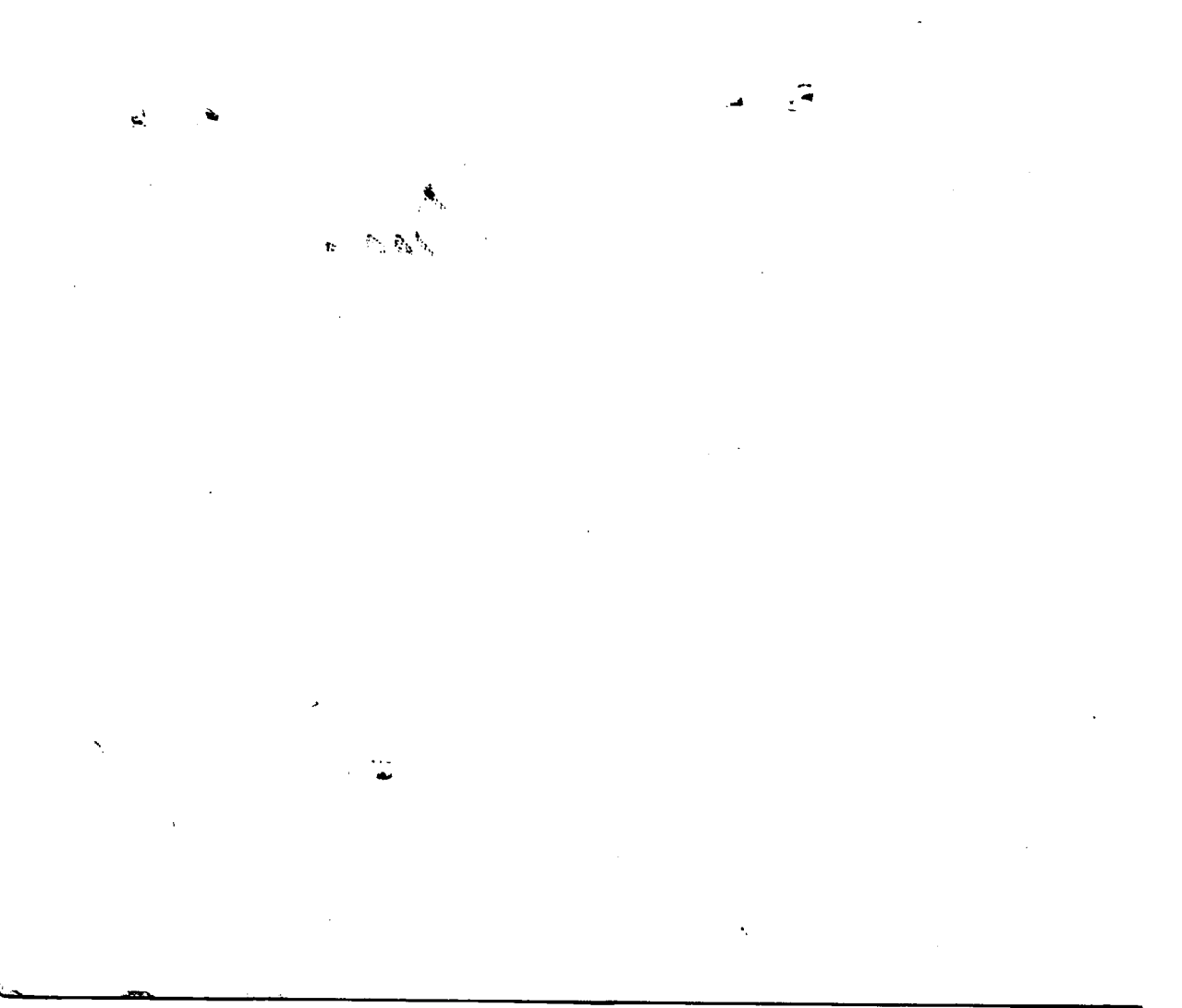
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. L. White M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address Lewiston, Ida.
 Filed 7-10-30 192__
M. L. K. Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. _____

County of Naz. Parca.

Registration District No. _____

City of Lewiston.

Primary Registration District No. 1009

Local Registrar's No. _____

(No. 2203 8th. Ave.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jesse Walter Mundell.

(a) Residence. No. 2203 8th. Ave. St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.. 4. COLOR OR RACE White. 5. Single, Married, Widowed, or Divorced (write the word) Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 24th, 1930.

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston,
(State or country) Idaho.

10. NAME OF FATHER L. E. Mundell.

11. BIRTHPLACE OF FATHER (city or town) Hugo,
(State or Country) Colorado.

12. MAIDEN NAME OF MOTHER Verna Swartz.

13. BIRTHPLACE OF MOTHER (city or town) Boulder,
(State or Country) Colorado.

14. Informant J. W. Mundell.
(Address) Lewiston, Idaho.

15. Filed Jan 1, 1930. STAN E. BROWN
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 24th, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

4/24-30, 1930, to 4/24-30, 1930

that I last saw him alive on _____, 1930

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Phys.
(Signed) W. H. Brown M.D., M. D.

4/24/30., 1930 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Lewiston, Idaho.

4/25/30. 19

20. Undertaker

Address

Brower-Vann Company

Lewiston, Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH <u>Idaho</u> JUL 8 1930		STATE OF IDAHO	
County of <u>Boz. Pence</u>		DEPARTMENT OF PUBLIC WELFARE	
City of <u>Southwick</u>		BUREAU OF VITAL STATISTICS	
		CERTIFICATE OF BIRTH	
No. <u>386-105-035-314</u> St.		Registration District No. <u>63</u> State File No. <u>182586</u>	
(If born in hospital or institution give name.)		Prim. Registration District No. Local Registrar's No.	
FULL NAME OF CHILD <u>No home still Born</u>			
(If stillborn, substitute the word "Stillbirth" for name of child)			
Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u> Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>6. 5th, 1930</u> (Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? <u>None needed</u>			
Number of child of this mother, including present birth <u>6</u> (a) Born alive and now living <u>5</u>			
Born alive but now dead <u>none</u> Stillborn <u>one</u>			
FATHER		MOTHER	
FULL NAME <u>Arthur Thornton</u>	FULL MAIDEN NAME <u>Helen Lamb</u>		
Residence (Usual place of abode) <u>Southwick Id</u>	Residence (Usual place of abode) <u>Southwick Id</u>		
If nonresident, give place and State <u>-</u>	If nonresident, give place and State <u>-</u>		
Color or race <u>White</u> Age at last Birthday <u>28</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>30</u> (Years)		
Birthplace <u>Idaho</u> (City and State or Country)	Birthplace <u>England</u> (City and State or Country)		
Occupation <u>Miner</u>	Occupation <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 6 - P - M. on the date above stated.

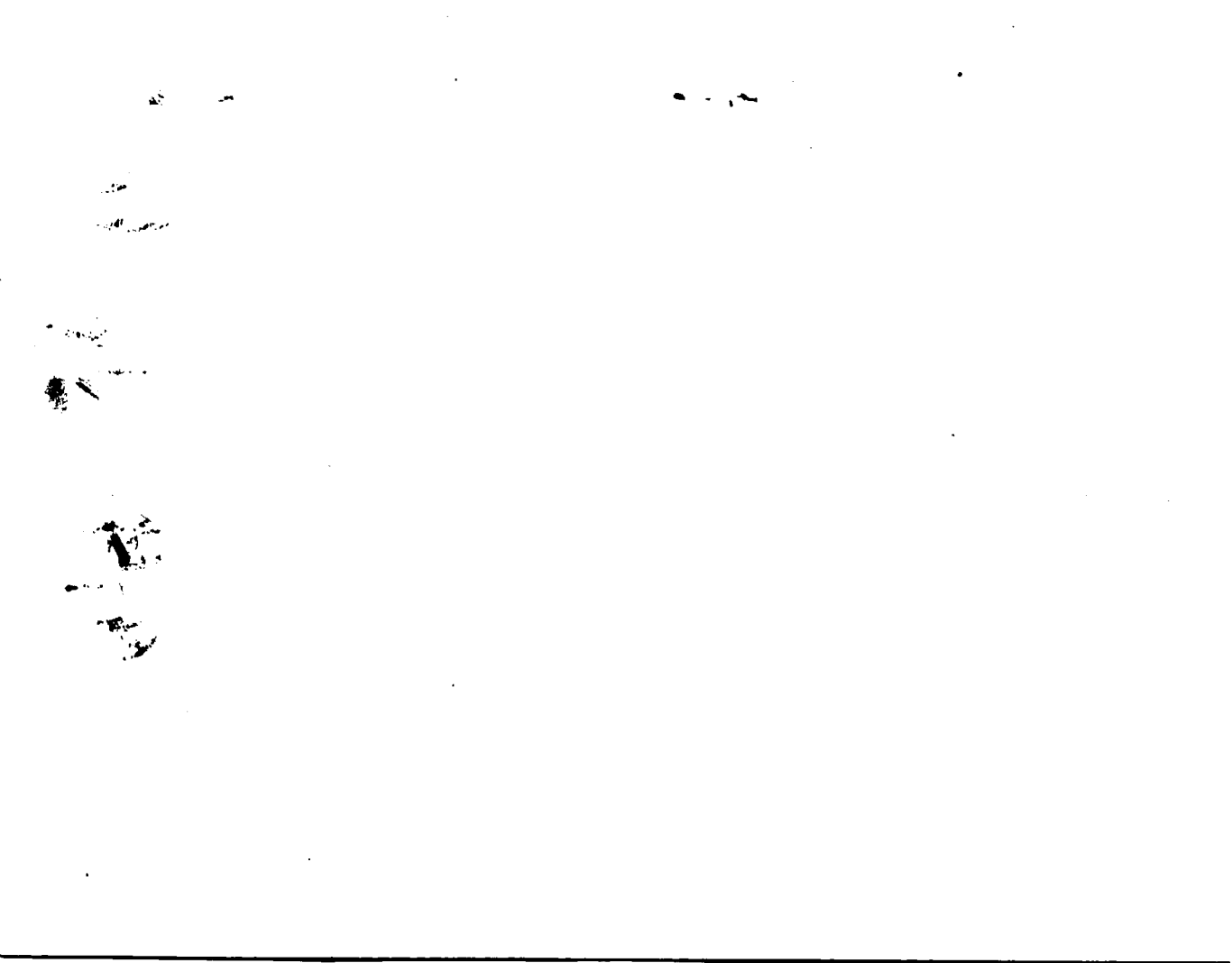
(Signature) Russell Thirtt

(Physician or midwife)

Address Southwick Id

Filed June 9 1930 B. F. Nesbit Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED JUL 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71124

PLACE OF DEATH

County of Nez Perce
City of Southwick

Registration District No.
Primary Registration District No. 63

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME None Still Born which was in uterus

(a) Residence. No. Southwick Ida St.

(Usual place of abode)
Length of residence in city or town where death occurred. 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Neither

6. DATE OF BIRTH (month, day and year)

7. AGE 0 Years 0 Months 0 Days If LESS than 1 day, 0 hrs. or 0 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9. BIRTHPLACE (city or town) (State or country) Southwick Ida

10. NAME OF FATHER Arthur Thornton

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ida

12. MAIDEN NAME OF MOTHER Helen Lamb

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Arthur Thornton (Address) Southwick Ida

15. Filed June 5, 1930 B.F. Nesbit Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 4th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4, 1930 to June 4, 1930
that I last saw him live on death in birth 1930
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:

died in uterus
Still Born

(duration) 1 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) None
(duration) 1 yrs. 1 mos. 1 ds.

18. Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Russell Hunt M. D.
June 4th, 1930 (Address) Southwick Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Southwick Cemetery Date of Burial June 5 1930

20. Undertaker None Address —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

18-586 +

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH JUL 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 182702

County of Twin Falls
City of Twin Falls
No. 212223 042 119 St.

T. F. C. & General Hosp.
(If born in hospital or institution
give name.)

Registration District No. 37 State File No. 182702

Prim. Registration District No. 2085 Local Registrar's No. 5 Stillbirth

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u> }	Legitimate? <u>Yes</u>	Date of birth <u>June 23</u> 19 <u>30</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 0 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME <u>Robert Caldwell Bayard</u>	FULL MAIDEN NAME <u>Florence Jarman</u>

Residence (Usual place of abode) Filer, RI

If nonresident, give place and State Idaho

Color or race W Age at last Birthday 21 (Years)

Birthplace Kan (City and State or Country)

Occupation Farmer

Color or race W Age at last Birthday 17 (Years)

Birthplace Wiggins Idaho (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 3:50 M. on the date above stated.

(Signature) J. A. Swartz

(Physician or midwife)

Address Filer, Ida

Filed July 9 1930 Elizabeth J. Smith Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

244-007-001-466
PLACE OF BIRTH RECEIVED AUG 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Ada
City of Meredian
No. R 3 St.

Registration District No. 11 State File No. 182791

(If born in hospital or institution give name.)

Prim. Registration District No. 2003 Local Registrar's No. 26

FULL NAME OF CHILD Baby Summers (Stillborn)

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth		
	(To be answered only in event of plural births)			Yes	7	7	1930
					(Month)	(Day)	(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 7 (a) Born alive and now living 6

Born alive but now dead Stillborn

FATHER
FULL NAME Chas. E. Summers

MOTHER
FULL MAIDEN NAME L. Vera Moore

Residence (Usual place of abode) Meredian R 3

Residence (Usual place of abode) Meredian R 3

If non-resident, give place and State

If non-resident, give place and State

Color or race white Age at last Birthday 39 (Years)

Color or race white Age at last Birthday 38 (Years)

Birthplace Harrison Arkansas (City and State or County)

Birthplace Harrison Arkansas (City and State or County)

Occupation Farmer

Occupation at home

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 5-30 a. M. on the date above stated.

(Signature) J. H. Neal

(Physician or midwife)

Address Meredian Idaho

Filed 8-1 1930 J. H. Neal

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED AUG 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71293

PLACE OF DEATH

County of Ada
City of Meridian

Registration District No.
Primary Registration District No.

Local Registrar's No. 10

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Barnes

(a) Residence. No. St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year)		
7. AGE	Years	Months
—	—	—
Days		If LESS than 1 day, hrs. or min.
—		—
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work. <u>None</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		

9. BIRTHPLACE (city or town) (State or country)	<u>Meridian</u> <u>Idaho</u>
10. NAME OF FATHER	<u>Charles E. Summers</u>
11. BIRTHPLACE OF FATHER (city or town) (State or Country)	<u>Arkness</u>
12. MAIDEN NAME OF MOTHER	<u>Dora Moore</u>
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)	<u>Arkness</u>

14. Informant	<u>Chas E Summers</u>
(Address)	<u>Meridian Id. R-3</u>
15. Filed	<u>7-8</u> , 19 <u>30</u>
	<u>J. F. Deane</u> Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH	<u>July</u> - <u>7</u> , 19 <u>30</u>
(Month)	(Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from	<u>7-7-30</u> , 19 <u>30</u> , to <u>7-7</u> , 19 <u>30</u>
that I last saw him on	<u>7-7</u> , 19 <u>30</u>
and that death occurred, on the date stated above, at	<u>520</u> m.
The CAUSE OF DEATH* was as follows: <u>Still Born due to injury to placenta which was only half normal size</u>	
(duration)	yrs. mos. ds.

CONTRIBUTORY (Secondary)

18. Where was disease contracted if not at place of death?	(duration) yrs. mos. ds.
Did an operation precede death?	Date of
Was there an autopsy?	
What test confirmed diagnosis?	
(Signed) <u>J. F. Deane</u> , M. D.	
<u>7-7</u> , 19 <u>30</u> (Address) <u>Meridian</u>	

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
<u>Meridian Cemetery</u>	<u>July 7</u> , 19 <u>30</u>
20. Undertaker	Address
<u>N. S. Mathis</u>	<u>Meridian</u>

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED SEP 6 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

- C.K. MACEY
SPECIAL AGENT

Boise, Idaho

AUG 22 1930

Mrs. C.E. Summers
Meridian

182791

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD

Baby.

PLACE OF
BIRTH

Meridian

DATE OF
BIRTH

July 7, 1930

SEX OF
CHILD

?

1. Number of children born to this mother, including present birth 7
2. Number born alive and now living 6
3. Born alive but now dead
4. Number of children stillborn 1

(Please write plainly)

Information with reference to

FATHER

Information with reference to

MOTHER

Charles E. Summers
(Full name)

Dora Summers
(Full maiden name)

Meridian
(Residence)

Meridian
(Residence)

Age at last birthday 39

Age at last birthday 38

Arkansas
(Birthplace)

Arkansas
(Birthplace)

Farming
(Occupation)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C. K. Macey
C. K. Macey

Special Agent, Bureau of the Census.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

517-122-009-793

PLACE RECEIVED AUG 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Banner
City of Sandpoint, Ida.

CERTIFICATE OF BIRTH 182985

No. 5 St. Parnell Hospital
(If born in hospital or institution
give name.)

Registration District No. 76 State File No. 106

Prim. Registration District No. 2155 Local Registrar's No. 106

FULL NAME OF CHILD Stillborn Eagan
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>July 22 1930</u> (Month) (Day) (Year)
--------------------------	-----------------------------------	-----------------------------------	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead Stillborn 1

FATHER
FULL NAME Fitz W. Eagan

MOTHER
FULL MAIDEN NAME Era M. Gilroy

Residence (Usual place of abode) Hope, Ida.

Residence (Usual place of abode) Hope, Ida.

If non-resident, give place and State

If non-resident, give place and State

Color or race White Age at last Birthday (Years)

Color or race White Age at last Birthday (Years)

Birthplace Cheney, Wash.
(City and State or County)

Birthplace Colorado
(City and State or County)

Occupation Trancher

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11:30 P. M.
on the date above stated.

(Signature) Floyd G. Wendle
M. D.
(Physician or midwife)

Address Sandpoint, Idaho

Filed Aug 4 1930 Viola Allen
Deputy Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
DIVISION OF BIRTH

Registration District No. _____
Birth Registration District No. _____

(If stillborn, registration for stillbirths is required in cases of stillborn)

Number of children in order of birth _____
Sex of child _____
Date of birth _____

Was the child ever in the hospital? _____

Number of child of this mother, including present birth _____

Even alive but how dead _____

Stillborn _____

Place of birth _____

Place of birth _____

Place of birth _____

Place of birth _____

Place of birth _____

Place of birth _____

Place of birth _____

Place of birth _____

Place of birth _____

Place of birth _____

Place of birth _____

Place of birth _____

Place of birth _____

Place of birth _____

Place of birth _____

Place of birth _____

Where there was an attending physician _____
Name of physician _____
Address _____
City _____
State _____
Zip _____

Address _____

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71349

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 28
Primary Registration District No. 2155

Local Registrar's No. 59

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Eagan(a) Residence. No. Hope, Ida. (rural) St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4. COLOR OF RACE White 5. Single Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 22, 1930

7. AGE Stillborn Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Sandpoint
(State or country) Idaho10. NAME OF FATHER Fitz W. Eagan11. BIRTHPLACE OF FATHER (city or town) Cheney
(State or Country) Wash.12. MAIDEN NAME OF MOTHER Eva. M. Hilroy13. BIRTHPLACE OF MOTHER (city or town) Colo.
(State or Country)14. Informant Fitz Eagan
(Address) Hope, Ida.15. Filed July 23, 1930 Viola Allen
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1930, to July 22 1930
that I last saw him at home and that death occurred, on the date stated above, at 11:00 m.

The CAUSE OF DEATH* was as follows:

Prolonged and difficult forceps delivery

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Alfred C. Hendricks D.
July 23, 1930 (Address) Sandpoint
Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lincrest Cemetery Date of Burial July 23 1930
20. Undertaker L. E. Mason Address Sandpoint, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

766-121-010 -386

PLACE OF BIRTH

AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonneville
City of Idaho Falls

CERTIFICATE OF BIRTH

183007

No. Spencer Hospital St. Registration District No. 73 State File No. 183007
(If born in hospital or institution give name.) Prim. Registration District No. 2145 Local Registrar's No. 316

FULL NAME OF CHILD Perry Powell
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>1</u> and <u>1</u>	Number in order of birth <u>3</u>	Legitimate? <u>yes</u>	Date of birth <u>June 21</u> 19 <u>30</u> (Month) (Day) (Year)
--------------------------	--	-----------------------------------	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 3 (a) Born alive and now living 1

Born alive but now dead 1 Stillborn 1

FULL NAME <u>Isaac Newton Powell</u>	FATHER	FULL MAIDEN NAME <u>Francis Thomas</u>	MOTHER
--------------------------------------	--------	--	--------

Residence (Usual place of abode) Jackson Wyom.

If non-resident, give place and State Wyom.

Color or race white Age at last Birthday 32 white Age at last Birthday 34
(Years) (Years)

Birthplace Jordan Valley Oregon Birthplace Cincinnati Ohio
(City and State or County) (City and State or County)

Occupation rancher Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 3 35 A. M.
on the date above stated.

(Signature) [Signature]

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Idaho Falls, Ida
(Physician or midwife)

Filed June 17 1930 Registrar.

RECORDED & INDEXED
JAN 10 1910
U. S. DEPARTMENT OF JUSTICE
DIVISION OF INVESTIGATION
WASHINGTON, D. C.

UNITED STATES DEPARTMENT OF JUSTICE
BUREAU OF INVESTIGATION
WASHINGTON, D. C.

Name of Subject		Date of Birth		Place of Birth	
John Doe		Jan 1, 1880		New York, N. Y.	
Occupation		Education		Political Party	
Clerk		High School		Democratic	
Previous Residence		Present Residence		Date of Arrival	
123 Main St, New York		456 Main St, New York		Jan 1, 1909	
Character of Case		Reference		Remarks	
Suspicion of Fraud		See Serial 100		Under investigation	
Date of Report		By		Special Agent	
Jan 10, 1910		J. A. Smith		J. A. Smith	

RECEIVED SEP 8 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho

AUG 22 1930

183007

Mrs. I.N. Powell
Jackson, Wyoming

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD

Perry Powell

PLACE OF
BIRTH

Idaho Falls, Idaho

DATE OF
BIRTH

June 21, 1930

SEX OF
CHILD

Male

1. Number of children born to this mother, including present birth *3*
2. Number born alive and now living *1*
3. Born alive but now dead *1*
4. Number of children stillborn *1*

(Please write plainly)

Information with reference to
FATHER

Information with reference to
MOTHER

Isaac Newton Powell
(Full name)

Frances Wellborn Thomas
(Full maiden name)

Jackson, Wyo
(Residence)

Jackson, Wyo.
(Residence)

Age at last birthday *34*

Age at last birthday *32*

Walla Walla, Wash.
(Birthplace)

Selma, Ala.
(Birthplace)

Rancher & Cattle-Man
(Occupation)

(High School Teacher)
(Occupation)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C. K. Macey
C.K. Macey

Special Agent, Bureau of the Census.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT
N. B.—In case of more than one child at birth a SEPARATE RETURN
for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF

(If born in hospital or institution
give name.)

Registration District No. 73

State of Idaho

FULL NAME OF CHILD

Prim. Registration District No. 2140

Local Registrar's No. 327

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child

male

Twin
Triplet
or other?

{ and }

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

(Month)

(Day)

(Year)

July 15 1930

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth. 5

Born alive but now dead. 1

(a) Born alive and now living. 2

Stillborn. 2

FULL
NAME

FATHER

Mark Lilson

FULL
MAIDEN
NAME

MOTHER

Etta Maughan

Residence (Usual place of abode) 520 N. Water, City

Residence (Usual place of abode) 520 N. Water, City

If non-resident, give place and State

If non-resident, give place and State

Color or race

White

Age at last Birthday

39 (Years)

Color or race

White

Age at last Birthday

38 (Years)

Birthplace

Riverton, Utah

(City and State or County)

Birthplace

Weston, Idaho

(City and State or County)

Occupation

Potato in sector

Occupation

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was

Born alive

Stillborn

at

11:25 A.M.

(Signature)

M. R. [Signature]

(Physician or midwife)

Address

Regley [Signature]

Filed

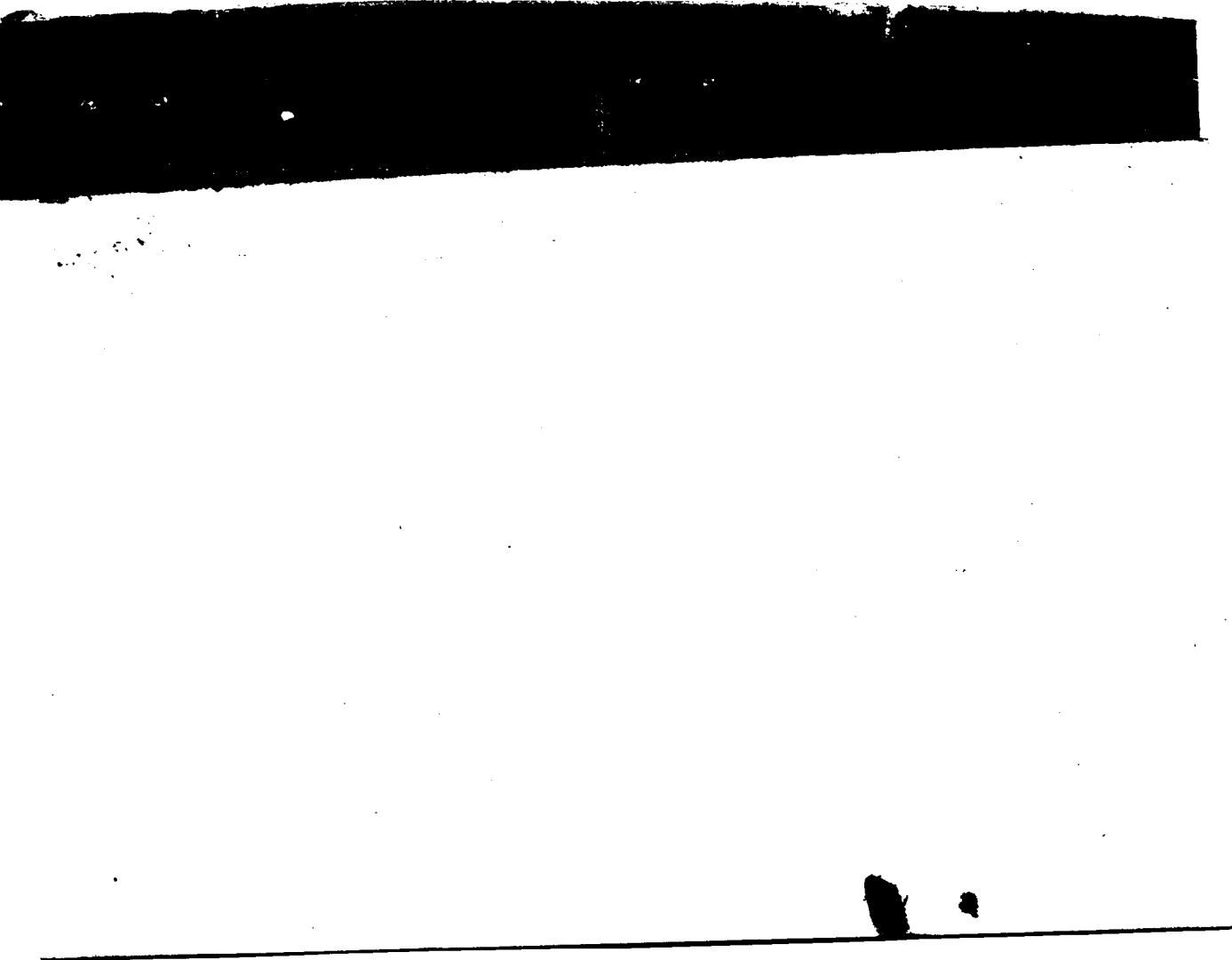
7/20

1930

Winn [Signature]

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

Registration District No. 73
Primary Registration District No. 2140
(No. L.D.S. Hospital)

(If death occurred in a hospital, or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 72328

Local Registrar's No. 190

2. FULL NAME Stillborn

(a) Residence. No. _____ St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Baby

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6. DATE OF BIRTH (month, day and year) July 15 1930
7. AGE Years _____ Months _____ Days _____ If LESS than 1 day _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (city or town) L.D.S. Hospital
(State or country)

10. NAME OF FATHER Mark Silex

11. BIRTHPLACE OF FATHER (city or town) Quinton
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Edith Mungman

13. BIRTHPLACE OF MOTHER (city or town) Western, Idaho
(State or Country)

14. Informant _____
(Address) _____

15. File At 3 19 30 41 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 15, 19 30
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15, 19 30, to July 15, 19 30, that I last saw h. _____ alive on _____, 19 _____, and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____
(Signed) J. R. Hart, M. D.
July 16, 19 30 (Address) Boyley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls, Idaho Date of Burial 19 _____

20. Undertaker _____ Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED AUG 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 183051

County of Canyon
City of Caldwell

386-129-018-713

Memorial Park Hospital

Registration District No. 3 State File No. 183051

(If born in hospital or institution
give name.)

Prim. Registration District No. 2005 Local Registrar's No. 134

FULL NAME OF CHILD Everett Ira Thompson

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	m	Twin Triplet or other?	and	Number in order of birth	Legiti- mate?	Date of birth	July 29 1930
		(To be answered only in event of plural births)				(Month) (Day) (Year)	

What prophylactic was used to prevent Ophthalmia Neonatorum? Argemol

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 1 Stillborn 1

FATHER FULL NAME James Thompson	MOTHER FULL MAIDEN NAME Vera Ballaway
------------------------------------	--

Residence (Usual place of abode) Caldwell Ida Caldwell

If nonresident, give place and State —

Color or race W Age at last Birthday 24 (Years)

Birthplace Nebraska (City and State or Country)

Occupation farmer housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 10 a. M.
on the date above stated.

(Signature) M. Montgomery

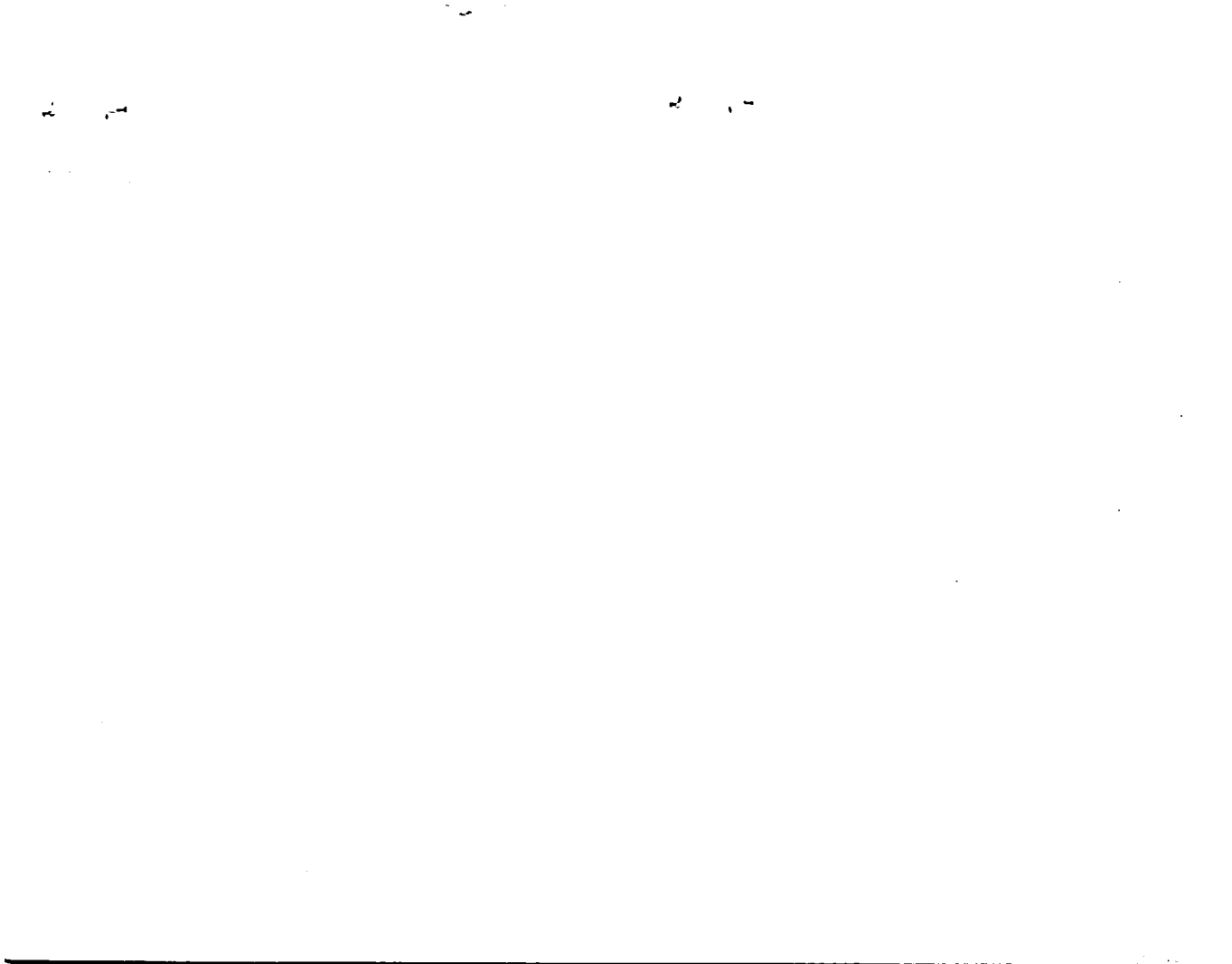
(Physician or midwife)

Address Caldwell Ida

Filed 7-30-1930 John C. Meyer

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
Physician should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO

RECEIVED AUG 12 1930

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

PLACE OF DEATH

County of CanyonCity of Caldwell

CERTIFICATE OF DEATH

Registration District No. 3Primary Registration District No. 2005 Local Registrar's No. 91

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Everett Ira Thompson

(a) Residence. No. St.

(Usual place of abode.)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. Single, Married, Widowed, or Divorced (write the word.)
-----------------------	----------------------------------	---

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) July 29, 1930

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
<u>Still born</u>				

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Caldwell, Idaho
(State or country)

10. NAME OF FATHER

James Thompson11. BIRTHPLACE OF FATHER (city or town) Nebraska
(State or Country)12. MAIDEN NAME OF MOTHER Vera Gallaway13. BIRTHPLACE OF MOTHER (city or town) Nebraska
(State or Country)14. Informant James Thompson
(Address) Huston, Idaho Rt #215. Filled 7-30-1930 John S. Meyer
Registrar.

DO NOT WRITE IN THIS SPACE

State File No. 71373

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 29, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 27, 1930 to July 29, 1930
that I last saw him alive on July 29, 1930and that death occurred, on the date stated above, at 10 a. m.*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:Pneumonia and

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Autopsy(Signed) John S. Meyer7/29, 1930 (Address) Caldwell, Idaho

19. Place of Burial, Cremation, or Removal

Date of Burial

Canyon Hill 7-30-1930

20. Undertaker

Address

Pa. & L. Case Caldwell Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Saleman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile Factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc., Women at home, who are engaged in the duties of the household only (not paid House-keepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia**; **Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.,** Carcinoma, Sarcoma, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping Cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

615-186-228-655
PLACE OF BIRTH
County of Coconino **RECEIVED AUG 11 1930**
City of Coomes' Place

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
S
CERTIFICATE OF BIRTH

No. 412- Lakeland St.
Lakeland Hosp.
(If born in hospital or institution give name.)
Registration District No. 30 State File No. 183227
Prim. Registration District No. 1050 Local Registrar's No. 118

FULL NAME OF CHILD Malvern LaRay Wang
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>7-6-30</u> (Month) (Day) (Year)
--------------------------	---	---	---------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____
Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Ludwig Wang
Residence (Usual place of abode) Coconino' Place
If non-resident, give place and State _____
Color or race W Age at last Birthday 41 (Years)
Birthplace Norway
(City and State or County)
Occupation Carpenter

MOTHER
FULL MAIDEN NAME Millie Overby
Residence (Usual place of abode) Coconino' Place
If non-resident, give place and State _____
Color or race W Age at last Birthday 39 (Years)
Birthplace Coconino' Place
(City and State or County)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 10:30 P. M.
on the date above stated.
(Signature) Harold J. Sturges

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Coconino' Place, Ida.
Filed 7/29 1930 H. J. Sturges
Registrar.

Where there was no attending physician
 or midwife, then the birth should be
 reported to the nearest A. S. S. N. or
 if one had been present, not
 report, but give evidence of his birth.

Address

Filed

I hereby certify that I attended the birth of this child, who was
 born on the date above stated.

(Signature)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(Occupation)

(Birthplace)

(Color or race)

(If one-month, give date and time)

(Place of birth)

(Name)

(Sex)

(Middletown)

(a) Born alive and now living

(b) Stillborn

(c) Stillborn

(d) Stillborn

(e) Stillborn

(f) Stillborn

(g) Stillborn

(h) Stillborn

(i) Stillborn

(j) Stillborn

(k) Stillborn

(l) Stillborn

WRITE PLAINLY, WITH UNFADING INK—THIS IS A REQUIREMENT.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

71436

RECEIVED AUG 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. ~~71284~~PLACE OF DEATH
County of Boole
City of Coeur d'Alene

Registration District No.

Primary Registration District No. Lakeside Hospital
(No. 1004-4th)Local Registrar's No. 912. FULL NAME Melvin Leroy Wang
(If death occurred in a hospital or institution, give its name instead of street and number.)(a) Residence. No. 1004-4th St. 204
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M.</u>	4. COLOR OR RACE <u>W.</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>single</u>		
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of				
6. DATE OF BIRTH (month, day and year) <u>1930-7-6</u>				
7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u> min.
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work. <u>0</u>				
(b) General nature of industry, business, or establishment in which employed (or employer)				
(c) Name of employer				

9. BIRTHPLACE (city or town) (State or country)	<u>Coeur d'Alene</u> <u>Idaho</u>
10. NAME OF FATHER	<u>Ludvig Wang</u>
11. BIRTHPLACE OF FATHER (city or town) (State or Country)	<u>Norway</u>
12. MAIDEN NAME OF MOTHER	<u>Millie Overby</u>
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)	<u>Cooperstown</u> <u>N. D.</u>

14. Informant (Address)	<u>Ludvig Wang</u> <u>Coeur d'Alene</u>
15. Filed <u>7-11</u> 19 <u>30</u>	<u>Idaho</u> <u>Registrar</u>

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH	<u>July</u> <u>6</u> 19 <u>30</u> (Month) (Day) (Year)
17. I HEREBY CERTIFY, that I attended deceased from <u>May</u> , 19 <u>30</u> , to <u>July</u> , 19 <u>30</u> , that I last saw her alive on <u>July</u> , 19 <u>30</u> , and that death occurred, on the date stated above, at <u>0</u> m. The CAUSE OF DEATH* was as follows: <u>Difficult + prolonged labor</u> <u>Still born</u>	
(duration) yrs. mos. ds.	

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.	
18. Where was disease contracted if not at place of death?	
Did an operation precede death?	<u>no</u> Date of
Was there an autopsy?	<u>no</u>
What test confirmed diagnosis?	<u>Exam</u>
(Signed)	<u>Hazel J. Stanger, M. D.</u>
<u>7-7</u> , 19 <u>30</u>	(Address) <u>Coeur d'Alene</u>

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
<u>Coeur d'Alene Nat'l Cem.</u>	<u>7-9</u> 19 <u>30</u>
20. Undertaker	Address
<u>Coeur d'Alene Home</u>	<u>Idaho</u>

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Salesman, (b) Grocery;** (a) **Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH AUG 16 1930

County of Lincoln
City of Salmon

No. St.

795-106-030-236

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 41 State File No. 183257

Prim. Registration District No. 2116 Local Registrar's No.

FULL NAME OF CHILD Stillborn (6 mark)

(If stillborn, substitute the word "Stillborn" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>ye</u>	Date of birth <u>June 6</u> 19 <u>30</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	-----------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead Stillborn

FATHER
FULL NAME Red Greg Mackey
Residence (Usual place of abode) Mackey
If nonresident, give place and State
Color or race Wht Age at last Birthday 26 (Years)
Birthplace Idaho
(City and State or Country)
Occupation Miner

MOTHER
FULL MAIDEN NAME Lucie Blood
Residence (Usual place of abode) Mackey
If nonresident, give place and State
Color or race Wht Age at last Birthday 22 (Years)
Birthplace Idaho
(City and State or Country)
Occupation Book

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive
Stillborn } at S a M.
on the date above stated.

(Signature) F B Meyer MD

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Salmon

Filed 19..... Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth returned.

PLACE OF BIRTH

County of Franklin City of ShoshoneNo. 35508032243 St.(If born in hospital or institution
give name.)

Registration District No. _____ State File No. _____

Prim, Registration District No. _____ Local Registrar's No. 34FULL NAME OF CHILD Baby. — No name, stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate <u>yes</u>	Date of birth <u>Aug 8</u> (Month) (Day) (Year) <u>1930</u>
--------------------------	---	-----	--------------------------------	----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? noneNumber of child of this mother, including present birth 9 (a) Born alive and now living 4

Born alive but now dead _____

Stillborn _____

FATHER
FULL NAME Sister CapronResidence (Usual place of abode) ShoshoneIf nonresident, give place and State IdahoColor or race White Age at last Birthday 37 (Years)Birthplace Colo (City and State or Country)Occupation DraymanMOTHER
FULL MAIDEN NAME Violet ButlerResidence (Usual place of abode) ShoshoneIf nonresident, give place and State IdahoColor or race White Age at last Birthday 33 (Years)Birthplace Idaho (City and State or Country)Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 2 P M.
on the date above stated.

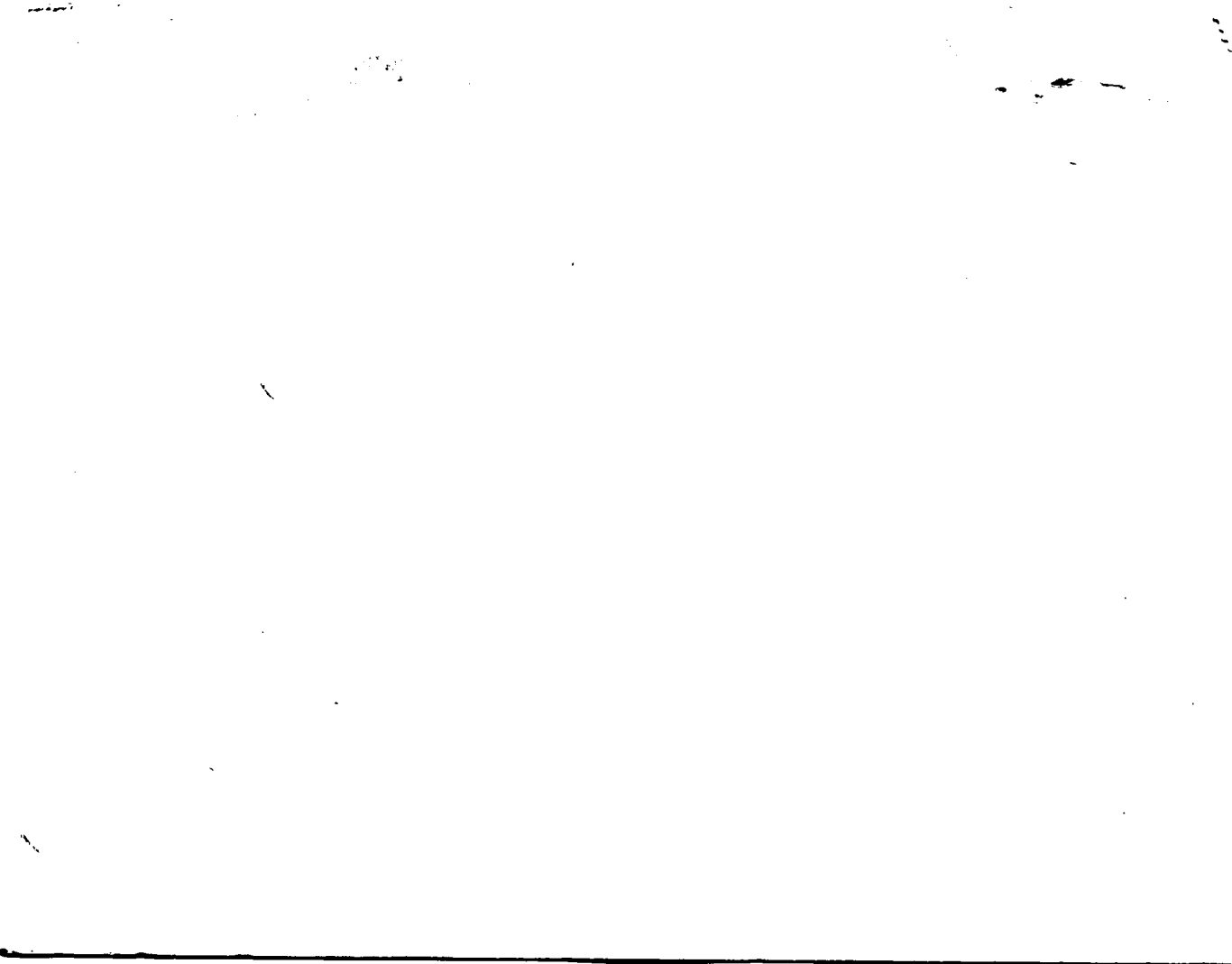
(Signature) _____

(Physician or midwife)

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Address _____

Filed Aug 9 1930Registrar. J. L. Fuller



WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

386-120-038-45
PLACE OF BIRTH
RECEIVED AUG 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

183356

County of Van Buren
City of Am Fall
No. _____ St. _____

Registration District No. 25 State File No. _____
Prim. Registration District No. 2072 Local Registrar's No. 52

(If born in hospital or institution
give name.)

FULL NAME OF CHILD Davie Lee Thompson
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	{ and { Number in order of birth	Legiti- mate? <u>ye</u>	Date of birth <u>July 20</u> 19 <u>30</u> (Month) (Day) (Year)
-----------------------------	---	---	-------------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? Ag. M. 3

Number of child of this mother, including present birth. 5 (a) Born alive and now living 4

Born alive but now dead. 0 Stillborn one (Edwampara)

FATHER FULL NAME <u>Lee L Thompson</u>	MOTHER FULL MAIDEN NAME <u>Agnes Davis</u>
---	---

Residence (Usual place of abode) <u>Am Fall</u>	Residence (Usual place of abode) <u>Am Fall</u>
---	---

If non-resident, give place and State. 0 If non-resident, give place and State 0

Color or race white Age at last Birthday 27 (Years) Color or race white Age at last Birthday 28 (Years)

Birthplace Mo (City and State or County) Birthplace Or (City and State or County)

Occupation Clerk Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive }
on the date above stated. { Stillborn } at _____ M.

(Signature) E. F. Schultz

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address _____

Filed Aug 2 1930 Emmerich Registrar.

[illegible]

show other evidence in the later birth, death in 1968 and other evidence not only showing that the latter was not alive, although this was not a finding of the latter's physician.

1. I hereby certify that
the above information is true and correct.

ORGANIZATION OF THE AMERICAN PHYSICIAN

1. The first of these is the fact that the
 2.
 3.
 4.
 5.
 6.
 7.
 8.
 9.
 10.
 11.
 12.
 13.
 14.
 15.
 16.
 17.
 18.
 19.
 20.
 21.
 22.
 23.
 24.
 25.
 26.
 27.
 28.
 29.
 30.
 31.
 32.
 33.
 34.
 35.
 36.
 37.
 38.
 39.
 40.
 41.
 42.
 43.
 44.
 45.
 46.
 47.
 48.
 49.
 50.
 51.
 52.
 53.
 54.
 55.
 56.
 57.
 58.
 59.
 60.
 61.
 62.
 63.
 64.
 65.
 66.
 67.
 68.
 69.
 70.
 71.
 72.
 73.
 74.
 75.
 76.
 77.
 78.
 79.
 80.
 81.
 82.
 83.
 84.
 85.
 86.
 87.
 88.
 89.
 90.
 91.
 92.
 93.
 94.
 95.
 96.
 97.
 98.
 99.
 100.
 101.
 102.
 103.
 104.
 105.
 106.
 107.
 108.
 109.
 110.
 111.
 112.
 113.
 114.
 115.
 116.
 117.
 118.
 119.
 120.
 121.
 122.
 123.
 124.
 125.
 126.
 127.
 128.
 129.
 130.
 131.
 132.
 133.
 134.
 135.
 136.
 137.
 138.
 139.
 140.
 141.
 142.
 143.
 144.
 145.
 146.
 147.
 148.
 149.
 150.
 151.
 152.
 153.
 154.
 155.
 156.
 157.
 158.
 159.
 160.
 161.
 162.
 163.
 164.
 165.
 166.
 167.
 168.
 169.
 170.
 171.
 172.
 173.
 174.
 175.
 176.
 177.
 178.
 179.
 180.
 181.
 182.
 183.
 184.
 185.
 186.
 187.
 188.
 189.
 190.
 191.
 192.
 193.
 194.
 195.
 196.
 197.
 198.
 199.
 200.
 201.
 202.
 203.
 204.
 205.
 206.
 207.
 208.
 209.
 210.
 211.
 212.
 213.
 214.
 215.
 216.
 217.
 218.
 219.
 220.
 221.
 222.
 223.
 224.
 225.
 226.
 227.
 228.
 229.
 230.
 231.
 232.
 233.
 234.
 235.
 236.
 237.
 238.
 239.
 240.
 241.
 242.
 243.
 244.
 245.
 246.
 247.
 248.
 249.
 250.
 251.
 252.
 253.
 254.
 255.
 256.
 257.
 258.
 259.
 260.
 261.
 262.
 263.
 264.
 265.
 266.
 267.
 268.
 269.
 270.
 271.
 272.
 273.
 274.
 275.
 276.
 277.
 278.
 279.
 280.
 281.
 282.
 283.
 284.
 285.
 286.
 287.
 288.
 289.
 290.
 291.
 292.
 293.
 294.
 295.
 296.
 297.
 298.
 299.
 300.
 301.
 302.
 303.
 304.
 305.
 306.
 307.
 308.
 309.
 310.
 311.
 312.
 313.
 314.
 315.
 316.
 317.
 318.
 319.
 320.
 321.
 322.
 323.
 324.
 325.
 326.
 327.
 328.
 329.
 330.
 331.
 332.
 333.
 334.
 335.
 336.
 337.
 338.
 339.
 340.
 341.
 342.
 343.
 344.
 345.
 346.
 347.
 348.
 349.
 350.
 351.
 352.
 353.
 354.
 355.
 356.
 357.
 358.
 359.
 360.
 361.
 362.
 363.
 364.
 365.
 366.
 367.
 368.
 369.
 370.
 371.
 372.
 373.
 374.
 375.
 376.
 377.
 378.
 379.
 380.
 381.
 382.
 383.
 384.
 385.
 386.
 387.
 388.
 389.
 390.
 391.
 392.
 393.
 394.
 395.
 396.
 397.
 398.
 399.
 400.
 401.
 402.
 403.
 404.
 405.
 406.
 407.
 408.
 409.
 410.
 411.
 412.
 413.
 414.
 415.
 416.
 417.
 418.
 419.
 420.
 421.
 422.
 423.
 424.
 425.
 426.
 427.
 428.
 429.
 430.
 431.
 432.
 433.
 434.
 435.
 436.
 437.
 438.
 439.
 440.
 441.
 442.
 443.
 444.
 445.
 446.
 447.
 448.
 449.
 450.
 451.
 452.
 453.
 454.
 455.
 456.
 457.
 458.
 459.
 460.
 461.
 462.
 463.
 464.
 465.
 466.
 467.
 468.
 469.
 470.
 471.
 472.
 473.
 474.
 475.
 476.
 477.
 478.
 479.
 480.
 481.
 482.
 483.
 484.
 485.
 486.
 487.
 488.
 489.
 490.
 491.
 492.
 493.
 494.
 495.
 496.
 497.
 498.
 499.
 500.
 501.
 502.
 503.
 504.
 505.
 506.
 507.
 508.
 509.
 510.
 511.
 512.
 513.
 514.
 515.
 516.
 517.
 518.
 519.
 520.
 521.
 522.
 523.
 524.
 525.
 526.
 527.
 528.
 529.
 530.
 531.
 532.
 533.
 534.
 535.
 536.
 537.
 538.
 539.
 540.
 541.
 542.
 543.
 544.
 545.
 546.
 547.
 548.
 549.
 550.
 551.
 552.
 553.
 554.
 555.
 556.
 557.
 558.
 559.
 560.
 561.
 562.
 563.
 564.
 565.
 566.
 567.
 568.
 569.
 570.
 571.
 572.
 573.
 574.
 575.
 576.
 577.
 578.
 579.
 580.
 581.
 582.
 583.
 584.
 585.
 586.
 587.
 588.
 589.
 590.
 591.
 592.
 593.
 594.
 595.
 596.
 597.
 598.
 599.

WILLIAM M. WILSON
JAMES H. WILSON

[illegible]

1947	1948	1949	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044	2045	2046	2047	2048	2049	2050	2051	2052	2053	2054	2055	2056	2057	2058	2059	2060	2061	2062	2063	2064	2065	2066	2067	2068	2069	2070	2071	2072	2073	2074	2075	2076	2077	2078	2079	2080	2081	2082	2083	2084	2085	2086	2087	2088	2089	2090	2091	2092	2093	2094	2095	2096	2097	2098	2099	2100	2101	2102	2103	2104	2105	2106	2107	2108	2109	2110	2111	2112	2113	2114	2115	2116	2117	2118	2119	2120	2121	2122	2123	2124	2125	2126	2127	2128	2129	2130	2131	2132	2133	2134	2135	2136	2137	2138	2139	2140	2141	2142	2143	2144	2145	2146	2147	2148	2149	2150	2151	2152	2153	2154	2155	2156	2157	2158	2159	2160	2161	2162	2163	2164	2165	2166	2167	2168	2169	2170	2171	2172	2173	2174	2175	2176	2177	2178	2179	2180	2181	2182	2183	2184	2185	2186	2187	2188	2189	2190	2191	2192	2193	2194	2195	2196	2197	2198	2199	2200	2201	2202	2203	2204	2205	2206	2207	2208	2209	2210	2211	2212	2213	2214	2215	2216	2217	2218	2219	2220	2221	2222	2223	2224	2225	2226	2227	2228	2229	2230	2231	2232	2233	2234	2235	2236	2237	2238	2239	2240	2241	2242	2243	2244	2245	2246	2247	2248	2249	2250	2251	2252	2253	2254	2255	2256	2257	2258	2259	2260	2261	2262	2263	2264	2265	2266	2267	2268	2269	2270	2271	2272	2273	2274	2275	2276	2277	2278	2279	2280	2281	2282	2283	2284	2285	2286	2287	2288	2289	2290	2291	2292	2293	2294	2295	2296	2297	2298	2299	2300	2301	2302	2303	2304	2305	2306	2307	2308	2309	2310	2311	2312	2313	2314	2315	2316	2317	2318	2319	2320	2321	2322	2323	2324	2325	2326	2327	2328	2329	2330	2331	2332	2333	2334	2335	2336	2337	2338	2339	2340	2341	2342	2343	2344	2345	2346	2347	2348	2349	2350	2351	2352	2353	2354	2355</
------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	--------

1. The first of these is the fact that the Commission has not yet received any information from the Government of the United Kingdom regarding the progress of its investigation into the alleged activities of the British Intelligence Service in the United States.

10-10-68

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 5 1930
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71491

County of Power
City of Ammon Falls

Registration District No. 23

Primary Registration District No. 2072

Local Registrar's No. 17

(No. _____)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME o

(a) Residence. No. Ammon Falls Id. St. (Still Birth)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day and year) 7

7 AGE Years Months Days If LESS than 1 day, hrs. min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Ammon Falls
(State or country)

10 NAME OF FATHER Leo G. Thompson

11 BIRTHPLACE OF FATHER (city or town) Mo.
(State or country)

12 MAIDEN NAME OF MOTHER Agnes Davis

13 BIRTHPLACE OF MOTHER (city or town) Id.
(State or country)

14 Informant Leo G. Thompson
(Address)

15 Filed Aug 4 1930 Genevieve North
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 20 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1930 to —, 19—
that I last saw him alive on —, 19—

and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

Mother and placenta
and

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) C. F. Schick, M. D.

7/21, 1930 (Address) Ammon Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial

19

20. Undertaker Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED SEP 3 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho

AUG 23 1930

183356

Mrs. L.G. Thompson BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
American Falls DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD Davis, Lea, Thompson.

PLACE OF BIRTH American Falls DATE OF BIRTH July 20, 1930 SEX OF CHILD Male

1. Number of children born to this mother, including present birth 5
2. Number born alive and now living 4
3. Born alive but now dead
4. Number of children stillborn I

(Please write plainly)

Information with reference to
FATHER

Leo Golden Thompson
(Full name)
American Falls Idaho.
(Residence)

Age at last birthday 37
Memphis Mo.
(Birthplace)

(Occupation)

Information with reference to
MOTHER

Agnes Irene Davis.
(Full maiden name)
American Falls Idaho.
(Residence)

Age at last birthday 28
Spray Oregon.
(Birthplace)

Engineer.

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C.K. Macey
C.K. Macey

Special Agent, Bureau of the Census.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

299-108-042-319
PLACE RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

183384

County of Twin Falls
City of Twin Falls

No. _____ St. _____

I. J. Co Hospital
(If born in hospital or institution give name.)

Registration District No. 37 State File No. _____

Prim. Registration District No. 2285 Local Registrar's No. _____

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>M</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>July 8</u> (Month) (Day) (Year) <u>1930</u>
-----------------------	---	--------------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead _____ Stillborn 1

FATHER
FULL NAME Harry A. Brizee

Residence (Usual place of abode) Twin Falls

If nonresident, give place and State _____

Color or race W Age at last Birthday 47 (Years)

Birthplace Watertown S. Dak
(City and State or Country)

Occupation _____

MOTHER
FULL MAIDEN NAME Lucille Cartwright

Residence (Usual place of abode) Twin Falls

If nonresident, give place and State _____

Color or race W Age at last Birthday 28 (Years)

Birthplace Ely Nevada
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 4:30 P M. on the date above stated.

(Signature) J. J. Davis

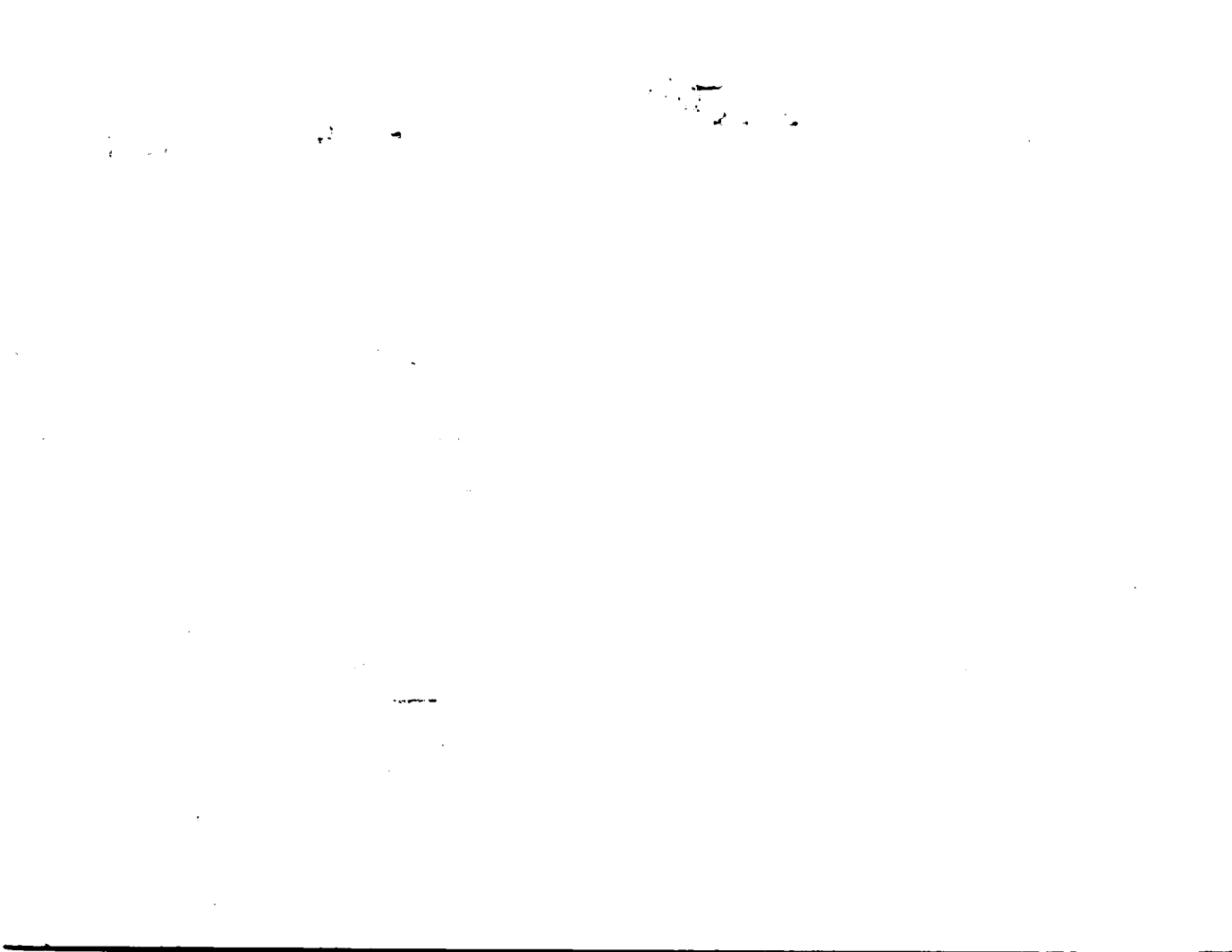
(Physician or midwife)

Address Kimberly Idaho

Filed August 16th 1930 Elizabeth J. Smith

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



FORM V. S. No. 5-25 M. 1-16-13

RECEIVED AUG 14 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 71507

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Lincoln
City of Lincoln
(No. 20 First Hospital St.)

Registration District No. 37Primary Registration District No. 108572. FULL NAME Debby Brice

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single

6. DATE OF BIRTH

July 7 1930
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.IF LESS than 1 day
how many hrs. or
min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Lincoln

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) So. Dakota

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) W.V.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. G. Brice(Address) Lincoln

15.

Filed August 6 1930Eligibility Smith
Local Registrar

16. DATE OF DEATH

July 7 1930
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from July 7 1930 to July 7 1930that I last saw him alive on July 7 1930and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Maternal Toxicosis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Davis M. D.1930 (Address) Lincoln

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days In the State... yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lincoln July 10 1930

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH AUG 4 1930
County of Franklin
City of Ruhle
No. RR St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

183421

Registration District No. 39 State File No.

(If born in hospital or institution
give name.)

Prim. Registration District No. 2087 Local Registrar's No.

FULL NAME OF CHILD Un Named

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>boy</u>	Twin <u>One</u> Triplet <u>One</u> or other? <u></u>	Number in order of birth <u>6</u>	Legitimate? <u>yes</u>	Date of birth <u>June 16</u> 19 <u>30</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth. 6 (a) Born alive and now living. 3

Born alive but now dead. 3 Stillborn. 3

FATHER
FULL NAME Joe Baxter
Residence (Usual place of abode) Ruhle Ida

If nonresident, give place and State
Color or race white Age at last Birthday 45 (Years)
Birthplace Kansas
(City and State or Country)
Occupation farmer

MOTHER
FULL MAIDEN NAME Elsie Dyer
Residence (Usual place of abode) Ruhle Ida

If nonresident, give place and State
Color or race white Age at last Birthday 40 (Years)
Birthplace Kansas
(City and State or Country)
Occupation house wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 4309 M.
on the date above stated.

(Signature) R. E. Sturges

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Ruhle Ida

Filed 7-5 1930 J. H. Murphy

Registrar.

THIS IS A COPY OF THE ORIGINAL RECORD OF THE BIRTH OF THE CHILD. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF BIRTHS.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 1 Birth Date 1911
Birth Registration District No. 1 Local Registrar's No. 1

FULL NAME OF CHILD

Full name, separating the word "and" (in case of child)
Child's name John
Date of birth 1911
Time of birth 10:00
Place of birth Idaho

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1
Born alive but now dead 0

FATHER John
MOTHER John

Residence (Usual place of abode) Idaho
Residence (Give place and State) Idaho

Color of race White
Date of birth 1911

Place of birth Idaho
City and State of Country Idaho

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born 1911
at the date above stated.

(Signature)

Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address

(Print name of midwife)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 77194

PLACE OF DEATH
County of Ada
City of Buhl

Registration District No. 39
Primary Registration District No. 2087

Local Registrar's No. 706

(If death occurred in a hospital or institution, give its name instead of street and number.)
(No. _____)

2. FULL NAME Betty Dean Baxter

(a) Residence. No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

1. SEX <u>Male</u>	4. COLOR OR RACE <u>white</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____		
6. DATE OF BIRTH (month, day and year) <u>June 16 1930</u>		
7. AGE	Years <u>-</u>	Months <u>-</u> Days <u>7</u> If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		

PARENTS	9. BIRTHPLACE (city or town) (State or country) <u>Buhl Idaho</u>
	10. NAME OF FATHER <u>Joe Baxter</u>
	11. BIRTHPLACE OF FATHER (city or town) (State or Country) <u>Kansas</u>
	12. MOTHER'S NAME OF MOTHER <u>Stacy Dix</u>
	13. BIRTHPLACE OF MOTHER (city or town) (State or Country) <u>Kansas</u>
14. Informant <u>J. W. Campbell</u> (Address) <u>Buhl Idaho</u>	
15. Filed <u>6-16-1930</u> <u>J. H. Murphy</u> Registrar	

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH <u>June 15th 1930</u> (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from <u>Still Born</u> that I last saw him alive on _____, 19____ and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Pre natal death</u> (duration) _____ yrs. _____ mos. _____ ds. CONTRIBUTORY (Secondary) <u>Extreme Obesity of mother</u> (duration) _____ yrs. _____ mos. _____ ds.
18. Where was disease contracted if not at place of death? _____ Did an operation precede death? _____ Date of _____ Was there an autopsy? _____ What test confirmed diagnosis? _____ (Signed) <u>Reed Curtis</u> M. D. _____, 19____ (Address) <u>Buhl Idaho</u>

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal <u>Buhl Cemetery</u>	Date of Burial <u>6/16 1930</u>
20. Undertaker <u>Wills of Buhl</u>	Address <u>Buhl Idaho</u>

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of BRECEIVED
City of Pocatello
No. St. Anthony St.

SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Hosp.
(If born in hospital or institution
give name.)

Registration District No. 28 State File No. 183580

Prim. Registration District No. 2161 Local Registrar's No. 9944

FULL NAME OF CHILD Stillbirth Walker
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> }</u> and <u> }</u> Number in order of birth <u> }</u>	Legitimate? <u>yes</u>	Date of birth <u>8-15-1930</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead Stillborn

FATHER FULL NAME <u>Ray H Walker</u>	MOTHER FULL MAIDEN NAME <u>Freda Schmid</u>
---	--

Residence (Usual place of abode) <u>1045 E. Fremont</u>	Residence (Usual place of abode) <u>1045 E. Fremont</u>
---	---

If non-resident, give place and State <u> </u>	If non-resident, give place and State <u> </u>
--	--

Color or race <u>W</u> Age at last Birthday <u>38</u> (Years)	Color or race <u>W</u> Age at last Birthday <u>38</u> (Years)
---	---

Birthplace <u>Kansas City Missouri</u> (City and State or County)	Birthplace <u>Paris Idaho</u> (City and State or County)
--	---

Occupation <u>Engineer</u>	Occupation <u> </u>
----------------------------	---------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 1045 P. M.
on the date above stated.

(Signature) [Signature]

(Physician or midwife)

Address Pocatello

Filed 9-1 19 31 J R Young
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 1158

PLACE OF DEATH

County of Bannock
City of PocatelloRegistration District No. 28Primary Registration District No. 2161Local Registrar's No. 5883(No. St. Anthony's Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nettie Ann Walker(a) Residence. No. Pocatello, Idaho. St.

(Usual place of abode)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year) <u>August 15, 1930.</u>		
7. AGE <u>Still-born</u>	Years Months Days	If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <u>None</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>Infant</u>		
(c) Name of employer		
9. BIRTHPLACE (city or town) <u>Pocatello, Idaho.</u> (State or country)		

PARENTS	10. NAME OF FATHER <u>Ray H. Walker</u>
	11. BIRTHPLACE OF FATHER (city or town) (State or Country) <u>Kansas, Missouri.</u>
	12. MAIDEN NAME OF MOTHER <u>Feda Schmid</u>
	13. BIRTHPLACE OF MOTHER (city or town) (State or Country) <u>Paris, Idaho.</u>

14. Informant Ray H. Walker
(Address) 1045 East Freman St. Poca.. Ida.15. Filed 8/16/30., 19

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
August 15, 1930.
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
8-15, 1930, to 8-15, 1930

that I last saw h— alive on —, 19—

and that death occurred, on the date stated above, at —m.

The CAUSE OF DEATH* was as follows:

Still-born due to
pre-partum hemorrhage
(duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [Signature] M. D.
8/16/30., 19 (Address) Pocatello, Ida.*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.19. Place of Burial, Cremation, or Removal
Mountain View Cemetery
Pocatello, Idaho. Date of Burial
8/16/30.¹⁹20. Undertaker
Arthur W. Hall Address
Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

212-225-006-464
PLACE OR RECEIVED SEP 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

183632

County of Bingham
City of Pinegre
No. _____ St. _____
Back Hospital Registration District No. 121 State File No. _____
(If born in hospital or institution give name.) Prim. Registration District No. 121 Local Registrar's No. 267
FULL NAME OF CHILD Stillborn Baker
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>Aug 25</u> 19 <u>30</u> (Month) (Day) (Year)
----------------------------	------------------------------	-----------	--------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth. 2 (a) Born alive and now living. 1
Born alive but now dead. 0 Stillborn 1

FULL NAME <u>Raymond E. Baker</u> FATHER <u>Pinegre</u>	FULL MAIDEN NAME <u>Grace Mae Dodge</u> MOTHER <u>Pinegre</u>
Residence (Usual place of abode) _____	Residence (Usual place of abode) _____
It non-resident, give place and State _____	It non-resident, give place and State _____
Color or race <u>White</u> Age at last Birthday <u>32</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>22</u> (Years)
Birthplace <u>Missouri</u> (City and State or County)	Birthplace <u>Idaho</u> (City and State or County)
Occupation <u>Farmer</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn Deceased at 4:30 P. M. on the date above stated.
(Signature) W. W. Beck

(Physician or midwife)

Address Blackfoot, Idaho
Filed Sept 4 30 1930 Mr. H. A. L. E. Atkins Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

shows other evidence of life after birth.
 child is one that neither breathes nor
 it should make this return. A stillborn
 or mummified, then the father, householder,
 or other person there was no attending physician

on the date above stated.

I hereby certify that I attended the birth of this child, who was

born at

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

Occupation

(City and State or County)

Birthplace

(Years)

Age at last birthday

Color of hair

If non-indigenous, race and birth

Residence (Last place of abode)

NAME

CHILD

MOTHER

Stillborn

(a) Born alive and now living

and investigations were made to prevent Opuntia Neonatorum

(If answered only in case of stillbirth)

or other

with

of

of

of

of

of

of

of

of

of

RECEIVED SEP 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 7164

PLACE OF DEATH

County of BinghamCity of BlackfootRegistration District No. 121Primary Registration District No. 1007Local Registrar's No. 138(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Stillborn Baker(a) Residence. No. Pinegreed, Ida. St.(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. Single, Married, Widowed,
or Divorced (write the word)Single

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

Aug 25, 1930

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)Blackfoot, Ida

10. NAME OF FATHER

Raymond E. Baker11. BIRTHPLACE OF FATHER (city or town)
(State or Country)LamarMissouri

12. MAIDEN NAME OF MOTHER

Grace Mae Dodge13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)Idaho

14.

Informant

Raymond E. Baker

(Address)

Pinegreed, Idaho

15.

Filed

Aug 25, 1930Mr. H. E. Baker

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Stillborn Aug 25, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 25, 1930 to Aug 25, 1930that I last saw him alive on Stillborn, 19

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Placenta previaHad been dead
for 2 days 6th moCONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) W. W. Beck, M. D.8/25, 1930 (Address) Blackfoot, Ida*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Pinegreed, Idaho Aug 25, 1930

20. Undertaker

Raymond E. Baker

Address

Pinegreed, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

RECEIVED SEP 8 1930

PLACE OF BIRTH

County of Bingham
City of Blackfoot
No. RD # 1 St.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

183635

(If born in hospital or institution
give name.)

Registration District No. 121 State File No.
Prim. Registration District No. 2194 Local Registrar's No. 264

FULL NAME OF CHILD

Stillborn Chapman

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u> and <u> </u>	Number in order of birth <u> </u>	Legiti- mate? <u>Yes</u>	Date of birth <u>Aug 18</u> <u>1930</u>
(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 5 (a) Born alive and now living 3

Born alive but now dead 1 Stillborn 1

FATHER FULL NAME <u>Joseph Franklin Chapman</u>	MOTHER FULL MAIDEN NAME <u>Blanche Hale</u>
--	--

Residence (Usual place of abode) <u>Blackfoot</u>	Residence (Usual place of abode) <u>Blackfoot</u>
---	---

It non-resident, give place and date <u> </u>	It non-resident, give place and date <u> </u>
--	--

Color or race <u>White</u> Age at last Birthday <u>39</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>30</u> (Years)
---	---

Birthplace <u>Idaho</u> (City and State or County)	Birthplace <u>Utah</u> (City and State or County)
--	---

Occupation <u>Farmer</u>	Occupation <u>Housewife</u>
--------------------------	-----------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Respective Stillborn at 10:00 P. M.
on the date above stated.

(Signature) W. W. Beck

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Blackfoot, Idaho
Filed Sept. 4 1930 Mrs. Helen E. Vatrie
Registrar.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

REPORT OF BIRTH OF CHILD
Name of child at birth: [illegible]
Date of birth: [illegible]
Place of birth: [illegible]

NAME OF CHILD

First name: [illegible]
Last name: [illegible]
Middle name: [illegible]

Child was born to parents: [illegible]

Child was born at [illegible] including present with

(a) born alive and how lived

Child was born [illegible]

Child was born [illegible]

Child was born [illegible]

Child was born [illegible]

Child was born [illegible]

Child was born [illegible]

Child was born [illegible]

Child was born [illegible]

Child was born [illegible]

Child was born [illegible]

Child was born [illegible]

Child was born [illegible]

Child was born [illegible]

Child was born [illegible]

Child was born [illegible]

Child was born [illegible]

Child was born [illegible]

CERTIFICATE OF ATTESTATION OF BIRTH OF CHILD

I hereby certify that I attended the birth of this child, who was [illegible] at [illegible] on [illegible]

(Signature)

There was no attending physician
or midwife, and the child was born
at [illegible] and was born
and is now living and healthy
and is now living and healthy

Child was born [illegible]

Child was born [illegible]

Child was born [illegible]

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71015

PLACE OF DEATH

County of BinghamCity of BlackfootRegistration District No. 2Primary Registration District No. 2192Local Registrar's No. 124

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn Chapman

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) single5a. If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____6. DATE OF BIRTH (month, day and year) Aug 18, 19307. AGE Stillborn Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Blackfoot
(State or country) Idaho10. NAME OF FATHER Joseph Franklin Chapman11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)12. MAIDEN NAME OF MOTHER Blanche Hale13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)14. Informant Joseph F. Chapman
(Address) Blackfoot, Idaho R.D. #115. Filed Aug 19, 1930 Mo. Hale Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 18 1930
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Aug 10, 1930, to Aug 10, 1930
that I last saw him alive Stillborn, 1930
and that death occurred, on the date stated above, at 10:00 P. m.
The CAUSE OF DEATH* was as follows:Premature birth
6th mo

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Placenta previa
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____

Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) W. W. Beck, M. D.8/18, 1930 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal G.C. Cem. Blackfoot Date of Burial Aug 19, 193020. Undertaker J. F. Chapman Address Blackfoot, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH.

STATE OF IDAHO

County of Blaine

RECEIVED SEP 2 1930

1930

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

City of Hailey

CERTIFICATE OF BIRTH

No. St.

Registration District No. 57

State File No. 183656

(If born in hospital or institution
give name.)

Prim. Registration District No. 2022 Local Registrar's No. 41

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
child Female

Twin
Triplet
or other?
(To be answered only in event of plural births)

and

Number
in order
of birth

Legiti-
mate? Yes

Date of
birth 7 26 30

(Month)

(Day)

(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0

Stillborn 1

FULL
NAME George Jacobs

FATHER

Residence (Usual place of abode) Hailey, Ida

If nonresident, give place and State

Color or race White

Age at last Birthday 23

(Years)

Birthplace Hailey, Idaho

(City and State or Country)

Occupation Miner

FULL
MAIDEN
NAME Evelyn Delilah Stitt

MOTHER

Residence (Usual place of abode) Hailey, Ida

If nonresident, give place and State

Color or race White

Age at last Birthday 19

(Years)

Birthplace Selleme, Ida

(City and State or Country)

Occupation House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 5 a. m. M.
on the date above stated.

(Signature) E. J. Stitt

(Physician or midwife)

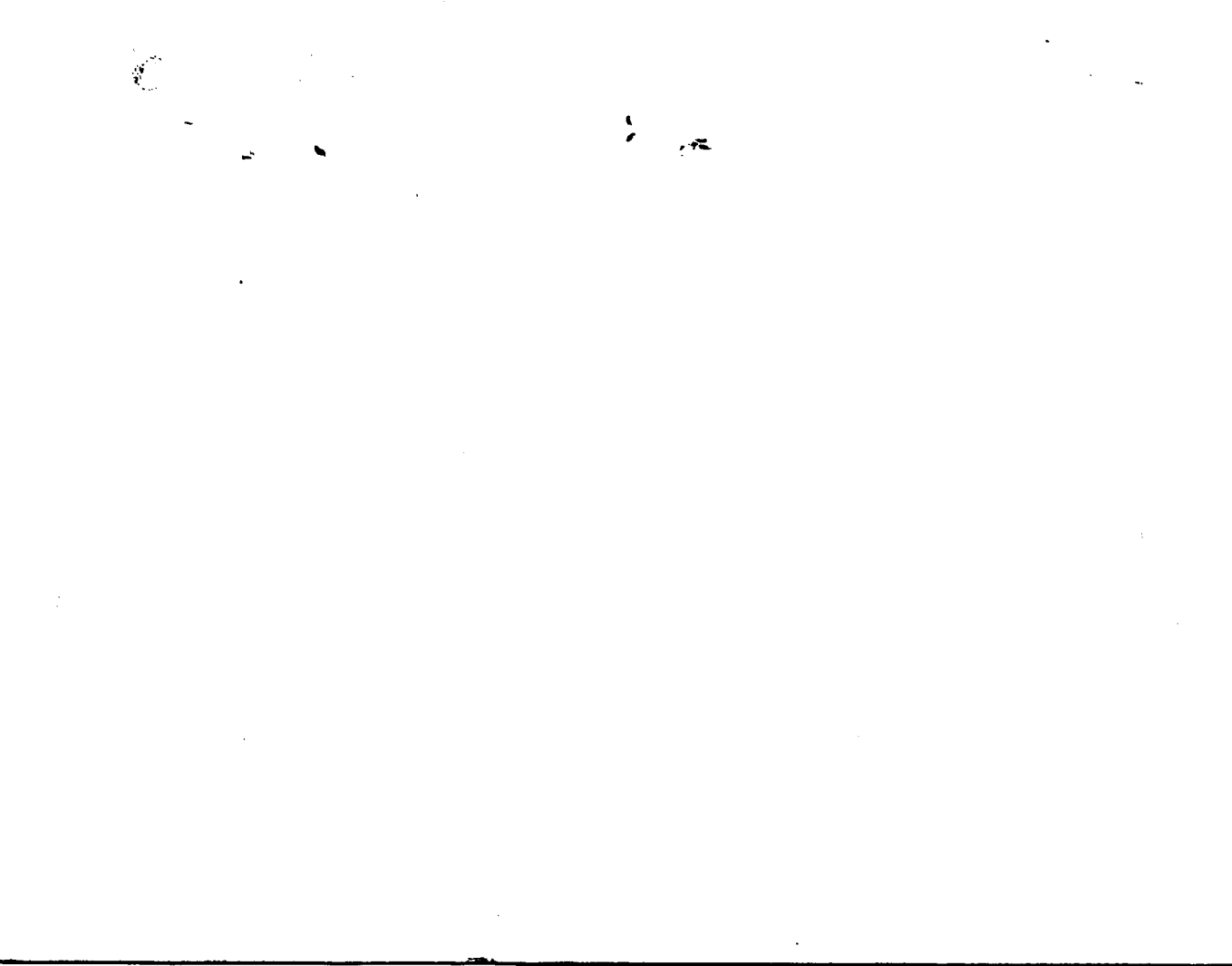
Address Hailey, Idaho

Filed 8-30 1930

1930

Registrar Robert H. Wright

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 2 1930
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 7162

County of Blaine

City of Hailey

Registration District No. 57

Primary Registration District No. 2022

Local Registrar's No. 24

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stanley Jacob

(a) Residence. No. St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

1. SEX Female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
21 10 10

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Hailey, Ida
(State or country)

10. NAME OF FATHER George Jacob

11. BIRTHPLACE OF FATHER (city or town) Hailey, Ida
(State or Country)

12. MARRIED NAME OF MOTHER Evelyn D. Smith

13. BIRTHPLACE OF MOTHER (city or town) Bellevue, Ida
(State or Country)

14. Informant Geo Jacob
(Address) 1 Hailey, Ida

15. Filed 8-30 1930 R. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 - 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....
that I last saw him, alive on....., 19.....
and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:
Strangled with cord

(duration) yrs. mos. 2 ds.
CONTRIBUTORY Hygiene regular
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted
If not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical

(Signed) E. W. F. M. D.
7/24 1930 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hailey, Ida Date of Burial 7/24 1930
20. Undertaker Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE ON FILE **SEP 2 1930** STATE OF IDAHO
County of Blaine DEPARTMENT OF PUBLIC WELFARE
City of Staley BUREAU OF VITAL STATISTICS
No. 795-214-007-319 CERTIFICATE OF BIRTH 183660
Registration District No. 57 State File No. 183660
(If born in hospital or institution give name.) Prim. Registration District No. 2028 Local Registrar's No. 37

FULL NAME OF CHILD _____
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and { Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>7-14-1930</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME <u>James E. Pierce</u>	FULL MAIDEN NAME <u>Ida Carey</u>	FULL NAME <u>Ida Carey</u>	FULL MAIDEN NAME <u>Ida Carey</u>
Residence (Usual place of abode) <u>Ida Carey</u>	Residence (Usual place of abode) <u>Ida Carey</u>	Residence (Usual place of abode) <u>Ida Carey</u>	Residence (Usual place of abode) <u>Ida Carey</u>
If nonresident, give place and State _____	If nonresident, give place and State _____	If nonresident, give place and State _____	If nonresident, give place and State _____
Color or race <u>White</u> Age at last Birthday <u>33</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>34</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>34</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>34</u> (Years)
Birthplace <u>New Mexico</u> (City and State or Country)	Birthplace <u>New Mexico</u> (City and State or Country)	Birthplace <u>New Mexico</u> (City and State or Country)	Birthplace <u>New Mexico</u> (City and State or Country)
Occupation <u>Farmer</u>	Occupation <u>Farmer</u>	Occupation <u>Farmer</u>	Occupation <u>Farmer</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 19 M.
on the date above stated.

(Signature) W. W. Fort

(Physician or midwife)

Address Staley, Idaho

Filed 8-30-1930 W. H. Wright
Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

10

11

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71012

PLACE OF DEATH
County of Blaine
City of Bailey

Registration District No. 59
Primary Registration District No. 2022

Local Registrar's No. 23

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Pierce

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min. Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Bailey (State or country)

10. NAME OF FATHER James C. Pierce

11. BIRTHPLACE OF FATHER (city or town) New Mexico (State or Country)

12. MAIDEN NAME OF MOTHER Ida Carey

13. BIRTHPLACE OF MOTHER (city or town) Idaho (State or Country)

14. Informant James C. Pierce (Address) Carey Idaho

15. Filed 8-30, 1930 P. S. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 14 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

7/14 1930, to 7/14 1930

that I last saw him alive on 7/14 1930

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows

Stillborn - Placenta previa in mother, Degeneration of placenta & low blood sugar fetus (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) 7/14 1930 (Address) Bailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Carey Idaho Date of Burial July 15 1930

20. Undertaker Hamilton Bailey

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACED ON FILE SEP 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

183667

County of Blaine
City of Hailey
No. 493-2241007 St. 415

Registration District No. 57 State File No. 183667
Prim. Registration District No. 5022 Local Registrar's No. 53

FULL NAME OF CHILD (Stillborn) Marilyn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twins or other? <u>and</u> Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>8-24</u> 19 <u>30</u> (Month) (Day) (Year)
----------------------------	--	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME <u>William Fredrick Pilworth</u>	FULL MAIDEN NAME <u>Sarah Davis</u>
Residence (Usual place of abode) <u>Carey, Ida</u>	Residence (Usual place of abode) <u>Carey, Ida</u>
If nonresident, give place and State	If nonresident, give place and State
Color or race <u>White</u> Age at last Birthday <u>35</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>34</u> (Years)
Birthplace <u>Idaho</u> (City and State or Country)	Birthplace <u>Davis</u> (City and State or Country)
Occupation <u>Farmer</u>	Occupation <u>Housewife</u>

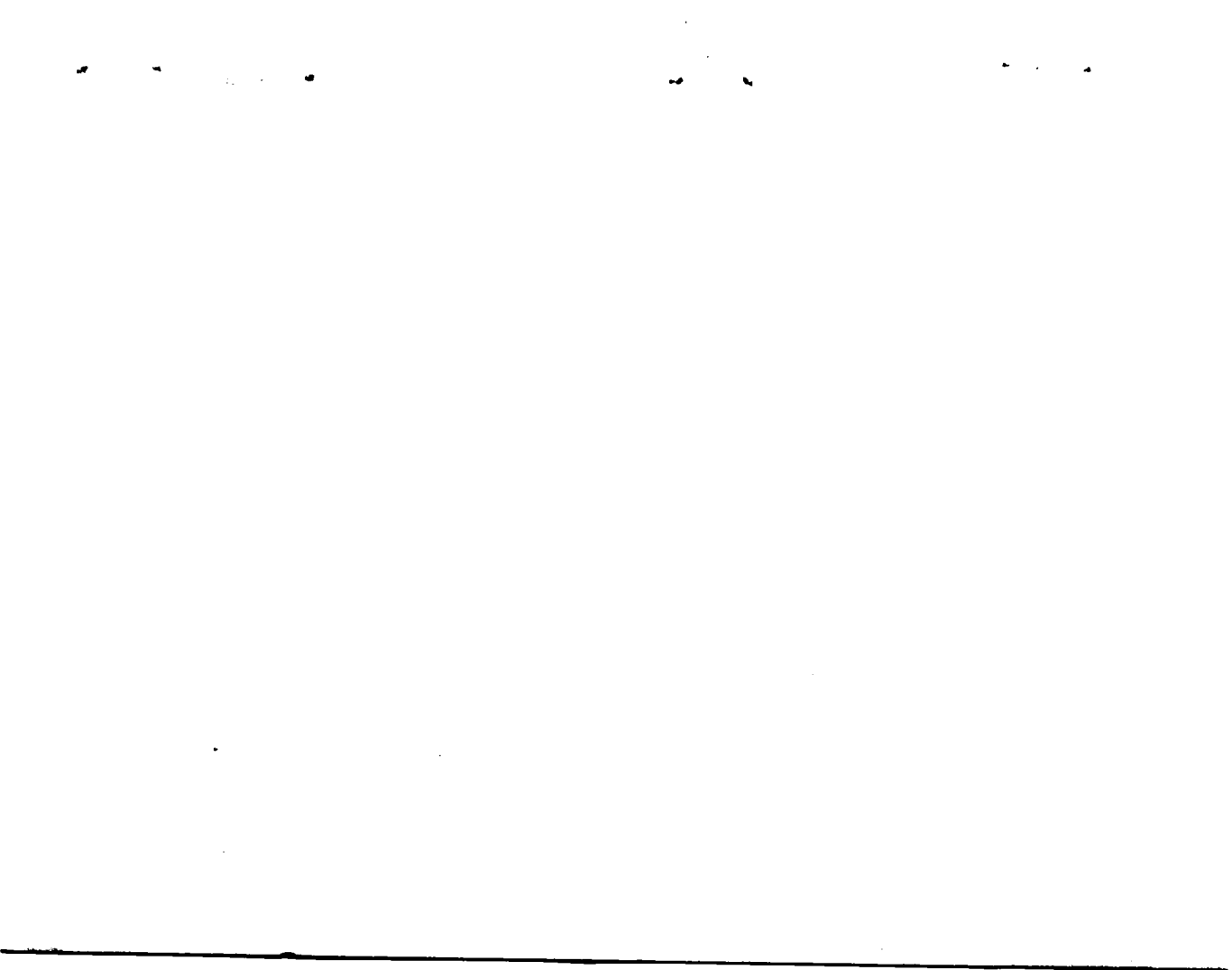
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 3:20 P. M. on the date above stated.

(Signature) Robert H. Wright
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Hailey, Ida
Filed 8-30 1930 Robert H. Wright Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County of Blaine
City of Carey

Registration District No. 57
Primary Registration District No. 2025

DO NOT WRITE IN THIS SPACE

State File No. 716Local Registrar's No. 25

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Dilworth(a) Residence. No. St. (Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year)		
7. AGE Years	Months	Days <u>Less than 1 day</u> hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (city or town) Failey, Idaho
(State or country)10. NAME OF FATHER William Friedrich Dilworth11. BIRTHPLACE OF FATHER (city or town)
(State or country) Paris, Idaho12. MAIDEN NAME OF MOTHER Sarah Davis13. BIRTHPLACE OF MOTHER (city or town)
(State or country) Paris, Idaho14. Informant W. F. Dilworth
(Address) Carey, Idaho15. Filled 8-30, 1930
W. F. Dilworth
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8-24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 19 , to , 19 that I last saw him alive on and that death occurred, on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH* was as follows:

Stillborn. Strangulation by umbilical cord.
Electrocution

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? No Date of Was there an autopsy? NoWhat test confirmed diagnosis? clinical(Signed) 8/24, 1930 (Address) Failey, Idaho
W. F. Dilworth, M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Carey, Idaho Date of Burial 8/25 193020. Undertaker Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

IVED OCT 15 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho SEP 22 1930

183667

Mrs. W.F. Dilworth
Carey

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD Mary Marilyn Dilworth
PLACE OF BIRTH Hailey DATE OF BIRTH Aug. 24, 1930 SEX OF CHILD Female

- 1. Number of children born to this mother, including present birth one
- 2. Number born alive and now living none
- 3. Born alive but now dead 11
- 4. Number of children stillborn one

(Please write plainly)

Information with reference to
FATHER
William Frederick Dilworth
(Full name)
Carey Idaho
(Residence)
Age at last birthday 36
Provo Utah
(Birthplace)
Sheep-man
(Occupation)

Information with reference to
MOTHER
Sarah Davis Dilworth
(Full maiden name)
Carey Idaho.
(Residence)
Age at last birthday 35
Paris, Idaho.
(Birthplace)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,
C. K. Macey
C.K. Macey
Special Agent, Bureau of the Census.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Carleton
City of Burley
No. 221 S. Overland St.

RECEIVED AUG 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

183791

(If born in hospital or institution
give name.)

Registration District No. 117 State File No. _____

Prim. Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD

Stillbirth - Ardell Phillips
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>boy</u>	Twin Triplet or other? (To be answered only in event of plural births)	{ and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>July 22</u> 19 <u>30</u> (Month) (Day) (Year)
----------------------------	---	---	--------------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth. 1 (a) Born alive and now living. 0

Born alive but now dead. _____ Stillborn 1

FATHER FULL NAME <u>Jack Silas Phillips</u>	MOTHER FULL MAIDEN NAME <u>Bessie Ida Hoyley</u>
--	---

Residence (Usual place of abode) <u>221 S. Overland</u>	Residence (Usual place of abode) <u>221 S. Overland</u>
---	---

If non-resident, give place and State _____	If non-resident, give place and State _____
---	---

Color or race <u>white</u> Age at last Birthday <u>30</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>19</u> (Years)
---	---

Birthplace <u>Franklin, Iowa</u> (City and State or County)	Birthplace <u>Burley, Idaho</u> (City and State or County)
---	--

Occupation <u>cook</u>	Occupation <u>housewife</u>
------------------------	-----------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3:50 P. M.
on the date above stated.

(Signature) L. H. Frazer, M.D.

(Physician or midwife)

Address Burley, Idaho

Filed 8-20-1930 F. H. Cress

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSRECEIVED AUG 23 1930
PLACE OF DEATHCounty of Cassia
City of BurleyRegistration District No. _____
Primary Registration District No. _____
(No. _____)

Local Registrar's No. _____

2. FULL NAME Ardell Phillips
(If death occurred in a hospital or institution, give its name instead of street and number.)
(a) Residence. No. _____ St. _____
(Usual place of abode.)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX M 4. COLOR OR RACE W 5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 22 1930

7. AGE Years Months Days Still Born
If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Burley
(State or country) Ida.10. NAME OF FATHER Jack P. Phillips11. BIRTHPLACE OF FATHER (city or town) Iowa
(State or Country)12. MAIDEN NAME OF MOTHER Bessie Ida Dayley13. BIRTHPLACE OF MOTHER (city or town) Burley
(State or Country)

14. Informant Jack P. Phillips
(Address) Burley Ida

15. Filed 20 - 1930 E. H. Cutler
Registrar.

DO NOT WRITE IN THIS SPACE

State File No. _____

71096

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1930 to July 22 1930
that I last saw him Stillborn 19____
and that death occurred, on the date stated above, at _____ m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Unhealed cord wound around neck (twice around) strangulation from tightening of cord.
(duration) _____ yrs. _____ mos. 0 ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____

Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) Deland Fager M. D._____, 19____ (Address) Burley, Idaho19. Place of Burial, Cremation, or Removal Burley Ida Date of Burial July 22 193020. Undertaker R. E. Johnson Address Burley

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Saleman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile Factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home**, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At Home**, and children not gainfully employed, as **At school or At Home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia); **Lobar Pneumonia**; **Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.**, **Carcinoma, Sarcoma, etc.**, of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping Cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED AUG 23 1930

County of Cassia
City of Burley
No. 320 N. Miller St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

183792

Registration District No. 117 State File No. _____
Prim. Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD

Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>boy</u>	Twin Triplet or other?	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>July 16</u> 19 <u>30</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 3 (a) Born alive and now living 0
Born alive but now dead 0 Stillborn 3

FATHER
FULL NAME Edward H. Stewart
Residence (Usual place of abode) Jarbridge, Nevada
If non-resident, give place and State _____
Color or race white Age at last Birthday 29 (Years)
Birthplace Salina, Kansas
(City and State or County)
Occupation miner

MOTHER
FULL MAIDEN NAME Neta Edna Frank
Residence (Usual place of abode) _____
If non-resident, give place and State Jarbridge, Nevada
Color or race white Age at last Birthday 36 (Years)
Birthplace Ogden, Utah
(City and State or County)
Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 8:00 M.
on the date above stated. (Signature) Edna Frank

(Physician or midwife)

Address Burley, Idaho
Filed 8-20-1930 J. H. Curtis
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

DEPARTMENT OF HEALTH AND WELFARE
BUREAU OF VITAL STATISTICS
STATE OF MICHIGAN

Registration District No. _____
Local Health Officer No. _____

For use by health officer or institution

LAST NAME OF CHILD

First Name of Child _____
Sex _____
Date of Birth _____
Time of Birth _____
Place of Birth _____
Weight at Birth _____
Length at Birth _____
Circumference at Birth _____

Is the child a resident of this district? _____
If not, where? _____
Is the child a resident of this state? _____
If not, where? _____

Is the child a resident of this country? _____
If not, where? _____
Is the child a resident of this world? _____
If not, where? _____

Is the child a resident of this district? _____
If not, where? _____
Is the child a resident of this state? _____
If not, where? _____

Is the child a resident of this country? _____
If not, where? _____
Is the child a resident of this world? _____
If not, where? _____

Is the child a resident of this district? _____
If not, where? _____
Is the child a resident of this state? _____
If not, where? _____

Is the child a resident of this country? _____
If not, where? _____
Is the child a resident of this world? _____
If not, where? _____

Is the child a resident of this district? _____
If not, where? _____
Is the child a resident of this state? _____
If not, where? _____

Where there was an attending physician
or midwife, then the father, householder,
etc. should make the return. A stillborn
child is one that neither mother nor
physician or midwife attended at the birth.

Is the child a resident of this district? _____
If not, where? _____
Is the child a resident of this state? _____
If not, where? _____

RECEIVED AUG 23 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 71689

PLACE OF DEATH

Cassia

CERTIFICATE OF DEATH

County of

City of Burley

Registration District No. 117

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Steward

(a) Residence. No. St.

(Usual place of abode.)

(If nonresident give city or town and State.)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. Single, Married, Widowed, or Divorced Single

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH July 16 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min. Still Born

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Burley Idaho.
(State or country)

10. NAME OF FATHER Edward Steward

11. BIRTHPLACE OF FATHER (city or town) Kansas
(State or Country)

12. MAIDEN NAME OF MOTHER Neta Fronk

13. BIRTHPLACE OF MOTHER Utah
(State or Country)14. Informant Mrs. A. C. Fronk
(Address) Burley Ida

15. Filed J-20-1930 F. H. Carter Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 16 1930

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 16 1930, to July 16 1930

that I last saw him alive on

and that death occurred on the date stated above, at

State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. The CAUSE OF DEATH was as follows:

Premature - Not of viable age - Abortus 5 months gestation

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. H. Carter, M. D.

Burley, Idaho

19. Place of Burial, Cremation, or Removal

Burley Ida

Date of Burial

July 16 1930

20. Undertaker D. E. Johnson

Address

Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Saleman, (b) Grocery;** (a) **Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of** (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

RECEIVED SEP 8 1930
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Franklin
City of Preston Idaho
No. _____ St. _____

CERTIFICATE OF BIRTH

183808

(If born in hospital or institution give name.)
Registration District No. 27 State File No. _____
Prim. Registration District No. 2119 Local Registrar's No. 186

FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and _____	Number in order of birth <u>4</u>	Legitimate? <u>yes</u>	Date of birth <u>8</u> <u>5</u> 19 <u>30</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth. 4 (a) Born alive and now living. 2
Born alive but now dead. none Stillborn 2

FATHER	MOTHER
FULL NAME <u>Carl Geo Neilson</u>	FULL MAIDEN NAME <u>Mrs. Abigail</u>
Residence (Usual place of abode) <u>Preston Idaho</u>	Residence (Usual place of abode) <u>Preston Idaho</u>
If non-resident, give place and State _____	If non-resident, give place and State _____
Color or race <u>White</u> Age at last Birthday <u>28</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>26</u> (Years)
Birthplace <u>Hyrum Utah</u> (City and State or County)	Birthplace <u>Paradise Utah</u> (City and State or County)
Occupation <u>farmer</u>	Occupation <u>housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 11:30 A M.
on the date above stated.

(Signature) Thos B Holder
Physician
(Physician or midwife)

Address Preston Idaho
Filed 9/10/30 19 1930

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

of any other evidence of his later death.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED SEP 2 1930

County of Gooding

City of Wendell

No. _____ St. _____

(If born in hospital or institution
give name.)

FULL NAME OF CHILD

Registration District No. _____ State File No. 183897

Prim. Registration District No. _____ Local Registrar's No. _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet <u>the</u> and or other?	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>July 5</u> 19 <u>30</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 3 (a) Born alive and now living 1

Born alive but now dead 1 Stillborn 1

FATHER FULL NAME <u>Vernon C. Iverson</u>	MOTHER FULL MAIDEN NAME <u>Thelma Johnson</u>
--	--

Residence (Usual place of abode) Wendell Idaho

If non-resident, give place and State _____

Color or race white Age at last Birthday 30 (Years)

Birthplace Utah (City and State or County)

Occupation Farmer

If non-resident, give place and State _____

Color or race white Age at last Birthday 28 (Years)

Birthplace Mexico (City and State or County)

Occupation House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive { Stillborn } at 4 P M.
on the date above stated.

(Signature) Chas. F. Zeller

(Physician or midwife)

Address Jerome Idaho

Filed 19

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

1. The first step is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.

...the ...
...the ...
...the ...
...the ...
...the ...

THE
NATIONAL ACADEMY
OF SCIENCES

...and ...

[illegible]

.....

[Faint, illegible markings]

1. RECEIVED
 2. DATE
 3. TIME
 4. BY
 5. INITIALS
 6. REMARKS
 7. RECEIVED
 8. DATE
 9. TIME
 10. BY
 11. INITIALS
 12. REMARKS
 13. RECEIVED
 14. DATE
 15. TIME
 16. BY
 17. INITIALS
 18. REMARKS
 19. RECEIVED
 20. DATE
 21. TIME
 22. BY
 23. INITIALS
 24. REMARKS
 25. RECEIVED
 26. DATE
 27. TIME
 28. BY
 29. INITIALS
 30. REMARKS
 31. RECEIVED
 32. DATE
 33. TIME
 34. BY
 35. INITIALS
 36. REMARKS
 37. RECEIVED
 38. DATE
 39. TIME
 40. BY
 41. INITIALS
 42. REMARKS
 43. RECEIVED
 44. DATE
 45. TIME
 46. BY
 47. INITIALS
 48. REMARKS
 49. RECEIVED
 50. DATE
 51. TIME
 52. BY
 53. INITIALS
 54. REMARKS
 55. RECEIVED
 56. DATE
 57. TIME
 58. BY
 59. INITIALS
 60. REMARKS
 61. RECEIVED
 62. DATE
 63. TIME
 64. BY
 65. INITIALS
 66. REMARKS
 67. RECEIVED
 68. DATE
 69. TIME
 70. BY
 71. INITIALS
 72. REMARKS
 73. RECEIVED
 74. DATE
 75. TIME
 76. BY
 77. INITIALS
 78. REMARKS
 79. RECEIVED
 80. DATE
 81. TIME
 82. BY
 83. INITIALS
 84. REMARKS
 85. RECEIVED
 86. DATE
 87. TIME
 88. BY
 89. INITIALS
 90. REMARKS
 91. RECEIVED
 92. DATE
 93. TIME
 94. BY
 95. INITIALS
 96. REMARKS
 97. RECEIVED
 98. DATE
 99. TIME
 100. BY
 101. INITIALS
 102. REMARKS
 103. RECEIVED
 104. DATE
 105. TIME
 106. BY
 107. INITIALS
 108. REMARKS
 109. RECEIVED
 110. DATE
 111. TIME
 112. BY
 113. INITIALS
 114. REMARKS
 115. RECEIVED
 116. DATE
 117. TIME
 118. BY
 119. INITIALS
 120. REMARKS
 121. RECEIVED
 122. DATE
 123. TIME
 124. BY
 125. INITIALS
 126. REMARKS
 127. RECEIVED
 128. DATE
 129. TIME
 130. BY
 131. INITIALS
 132. REMARKS
 133. RECEIVED
 134. DATE
 135. TIME
 136. BY
 137. INITIALS
 138. REMARKS
 139. RECEIVED
 140. DATE
 141. TIME
 142. BY
 143. INITIALS
 144. REMARKS
 145. RECEIVED
 146. DATE
 147. TIME
 148. BY
 149. INITIALS
 150. REMARKS
 151. RECEIVED
 152. DATE
 153. TIME
 154. BY
 155. INITIALS
 156. REMARKS
 157. RECEIVED
 158. DATE
 159. TIME
 160. BY
 161. INITIALS
 162. REMARKS
 163. RECEIVED
 164. DATE
 165. TIME
 166. BY
 167. INITIALS
 168. REMARKS
 169. RECEIVED
 170. DATE
 171. TIME
 172. BY
 173. INITIALS
 174. REMARKS
 175. RECEIVED
 176. DATE
 177. TIME
 178. BY
 179. INITIALS
 180. REMARKS
 181. RECEIVED
 182. DATE
 183. TIME
 184. BY
 185. INITIALS
 186. REMARKS
 187. RECEIVED
 188. DATE
 189. TIME
 190. BY
 191. INITIALS
 192. REMARKS
 193. RECEIVED
 194. DATE
 195. TIME
 196. BY
 197. INITIALS
 198. REMARKS
 199. RECEIVED
 200. DATE
 201. TIME
 202. BY
 203. INITIALS
 204. REMARKS
 205. RECEIVED
 206. DATE
 207. TIME
 208. BY
 209. INITIALS
 210. REMARKS
 211. RECEIVED
 212. DATE
 213. TIME
 214. BY
 215. INITIALS
 216. REMARKS
 217. RECEIVED
 218. DATE
 219. TIME
 220. BY
 221. INITIALS
 222. REMARKS
 223. RECEIVED
 224. DATE
 225. TIME
 226. BY
 227. INITIALS
 228. REMARKS
 229. RECEIVED
 230. DATE
 231. TIME
 232. BY
 233. INITIALS
 234. REMARKS
 235. RECEIVED
 236. DATE
 237. TIME
 238. BY
 239. INITIALS
 240. REMARKS
 241. RECEIVED
 242. DATE
 243. TIME
 244. BY
 245. INITIALS
 246. REMARKS
 247. RECEIVED

... now, this, and to give an answer to

(continued)

10-15-68

THE UNITED STATES OF AMERICA
DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

1961

1. The first step is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.

[Faint, illegible text]

1948

[illegible]

SECRET

100

WALLS TO WALLS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 2 1930
PLACE OF DEATH

County of Gooding
City of Wendell

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No.
Primary Registration District No.

DO NOT WRITE IN THIS SPACE

State File No. 7175

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Iverson

(a) Residence. No. St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Wendell Idaho
(State or country)

10. NAME OF FATHER Vernon C Iverson

11. BIRTHPLACE OF FATHER (city or town) Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Thelma Johnson

13. BIRTHPLACE OF MOTHER (city or town) Mexico
(State or Country)

14. Informant Vernon C Iverson
(Address) Wendell Idaho

15. Filed Sept 2, 1930 E L Swinton
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 5 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 5, 1930, to July 5, 1930
that I last saw him alive on July 5, 1930

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Premature Separation Placenta

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. P. Zeffler M. D.
7/10, 1930 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial
19
20. Undertaker Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of child stated.

PLACE OF BIRTH

RECEIVED SEP 11 1930
County of Boone
City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S184021

No. St.

712-116.028-152

Registration District No. 30 State File No.

(If born in hospital or institution
give name.)

Prim. Registration District No. 1050 Local Registrar's No. 157

FULL NAME OF CHILD Kieth Rasmussen

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>8</u> <u>16</u> <u>1930</u> (Month) (Day) (Year)
--------------------------	---	-------	--------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth..... (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>Harry Walter Rasmussen</u>	MOTHER FULL MAIDEN NAME <u>Eva Johanna Jensen</u>
---	--

Residence (Usual place of abode) Coeur d'Alene Ida

It non-resident, give place and State.....

Color or race White Age at last Birthday 23 (Years)

Birthplace Kalispell Mont (City and State or County)

Occupation Labourer

Residence (Usual place of abode) Coeur d'Alene Ida

It non-resident, give place and State.....

Color or race White Age at last Birthday 21 (Years)

Birthplace Elmira Wash (City and State or County)

Occupation Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive }
on the date above stated. Stillborn at 7 P M.

(Signature) E. H. Geed

(Physician or midwife)

Address Coeur d'Alene Ida

Filed 8/29 1930 N. J. Sturges

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

[illegible]

*7- There was no attending physician at Midville, than the father, householder, etc., should make his report. A child is one that delivers previous not shows other evidence of live after birth.

THE UNITED STATES OF AMERICA

[Horse alive]

Horse-drawn

modified new size 11 1/2

42706A

1951

(Lithograph of 1840s)

(continued)

34-

NOTES

121-107-10 OIRK WAS 710

NOTHING TO REPORT

5013 10-10-71

It was not until 1911 that the first

It is the most (1) and the most (2)

2301A-
3364

2000

Number of copies of this report furnished to each party

7-11-1961

1957-01-01
1957-01-01
1957-01-01

SECRET

7400000

-b7c

Armed

《中国新闻史》

450

It is also possible that the word "SILVER" is a misspelling of the word "SILVER".

Police Registration District No. _____ Local Registrar's No. _____

Registration District No. State File No.

STATE OF MICHIGAN

"CONFIDENTIALITY TO WASHINGTON"

ORDER TO CLERK

RECEIVED SEP 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71752

PLACE OF DEATH

County of *Kootenai*City of *Coeur d'Alene*Registration District No. *30*Primary Registration District No. *1057*Local Registrar's No. *117*

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME *Keith Rasmussen*(a) Residence. No. *817* *3rd* St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M.*4. COLOR OR RACE *W*5. Single, Married, Widowed, or Divorced (write the word) *single*

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) *1930-8-16*

7. AGE

Years

Months

Days

If LESS than 1 day,

0 hrs. or
0 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) *Coeur d'Alene*
(State or country) *Idaho*10. NAME OF FATHER *Harry Rasmussen*11. BIRTHPLACE OF FATHER (city or town)
(State or Country) *Kalisfel. Mont.*12. MAIDEN NAME OF MOTHER *Eva Jensen*13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) *Salt Lake Gardens. Utah*

14. Informant

(Address) *21 Amy Rasmussen*
*Coeur d'Alene*15. Filed *8/29* *1930* *H. J. Sturges* Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

8 *16* *1930*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

8-16- *1930* to *8-16-* *1930*that I last saw *him* alive on *Stillborn*, 19and that death occurred, on the date stated above, at *7* P. m.

The CAUSE OF DEATH was as follows:

Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

8-18- *1930* (Address) *E. H. Reed* M. D.
Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Funeral Home - Coeur d'Alene *8-18* *1930*

20. Undertaker

Address

Coeur d'Alene Funeral Home *Coeur d'Alene*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

184021

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED SEP 11 1930
County of Rootenai
City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 184023

No. 769-207-028-819 St.

Registration District No. 30 State File No. 1059

(If born in hospital or institution
give name.)

Prim. Registration District No. 1059 Local Registrar's No. 154

FULL NAME OF CHILD Ida Evelyn Gordon
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>female</u>	Twin Triplet or other? (To be answered only in event of plural births)	{ and }	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>6</u> <u>7</u> <u>1930</u> (Month) (Day) (Year)
-------------------------------	---	---------	--------------------------------	--------------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>George Lyle Gordon</u>	MOTHER FULL MAIDEN NAME <u>Mary Estella Harris</u>
---	---

Residence (Usual place of abode) Coeur d'Alene

If non-resident, give place and State

Color or race white Age at last Birthday 27 (Years)

Birthplace St. Maries Ida (City and State or County)

Occupation logger

If non-resident, give place and State

Color or race white Age at last Birthday

Birthplace Duby Mont (City and State or County)

Occupation Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 10:50 P.M.
on the date above stated. Stillborn

(Signature) E. H. Teed

(Physician or midwife)

Address Coeur d'Alene Ida

Filed 8/29 1930 N. J. Sturges
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

SECRET

12

10-10-68

10-11-68

(b)(7) (C) (b)(7) (D) (b)(7) (E) (b)(7) (F) (b)(7) (G) (b)(7) (H) (b)(7) (I) (b)(7) (J) (b)(7) (K) (b)(7) (L) (b)(7) (M) (b)(7) (N) (b)(7) (O) (b)(7) (P) (b)(7) (Q) (b)(7) (R) (b)(7) (S) (b)(7) (T) (b)(7) (U) (b)(7) (V) (b)(7) (W) (b)(7) (X) (b)(7) (Y) (b)(7) (Z)

Number of child of this mother including present birth (a) Born alive and now living

NAME _____
FATHER _____
MOTHER _____
BIRTH _____
BIRTH _____
BIRTH _____

Color of face: White at last birthday (Year) 1955

100-443888-100

1. I hereby certify that I attended the birth of this child, who was born on 11/11/1944.

10-10-68

There was no attending physician at this time, then the latter, household, etc. should make this report. A statement is made that neither brother nor sister showed any evidence of life after burial.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71073

County of Boole

Registration District No. 30

City of Coeur d'Alene

Primary Registration District No. 1950

Local Registrar's No. 75

(No. Coeur d'Alene Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ida Evelyn Gordon

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE W. 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Coeur d'Alene
(State or country) Idaho

10. NAME OF FATHER George Gordon

11. BIRTHPLACE OF FATHER (city or town) St. Maries
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER Stella Harris

13. BIRTHPLACE OF MOTHER (city or town) Montana
(State or Country)

14. Informant A. G. Worland
(Address) Coeur d'Alene, Idaho

15. Filed 6/16, 1930 H. J. Sturges M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

6 7 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH was as follows:

Stillborn

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. H. Teed, M. D.

6-8, 1930 (Address) Coeur d'Alene, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

First Cemetery - Coeur d'Alene

6/8 1930

20. Undertaker

Address

Coeur d'Alene Home - Coeur d'Alene, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

1840-3

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH SEP 10 1934

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

184109

County of Teton
City of Bozeman
No. St. Joseph's St.

Registration District No. 96 State File No. 184109

(If born in hospital or institution
give name.) Hospital

Prim. Registration District No. 1009 Local Registrar's No. S

FULL NAME OF CHILD Richard
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other?	{ and } in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>8</u> <u>20</u> <u>1934</u> (Month) (Day) (Year)
--------------------------	------------------------------	---------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 0 (a) Born alive and now living 0

Born alive but now dead 1 Stillborn 1

FULL NAME <u>Charles Roberts</u>	FATHER	FULL MAIDEN NAME <u>Anna Jensen</u>	MOTHER
-------------------------------------	--------	---	--------

Residence (Usual place of abode) Cloveland, Neb

Is non-resident, give place and State Nebraska

Color or race White Age at last Birthday 40 (Years)

Birthplace Nebraska (City and State or County)

Occupation Farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 4:55 P. M.
on the date above stated.

(Signature) E. J. Broadbent
Physician or midwife

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address 224 E. 2nd
Filed 9-2 1934 Registrar W. L. Lyle

S

COUNTY OF _____
 CITY OF _____
 No. _____
 (If born in hospital - institution)
 State of _____
 FULL NAME OF CHILD _____

to use
bldg

Number of child in this mother

From office but now dead

RECEIVED

7/1/77
Resident (C) and (D) of the

100-443887-100

Organization _____
 Birthplace _____
 Age and State of _____

10/10/70

on the 19th of May 1964

etc. should make this return
or otherwise, than the labor

Laborer other evidence of his

[illegible]

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71800

PLACE OF DEATH

County of NezperceCity of LewistonRegistration District No. 26Primary Registration District No. 1009Local Registrar's No. 204(No. St. Joseph Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Roberts(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 20, 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston, Ida.
(State or country)10. NAME OF FATHER C E Roberts11. BIRTHPLACE OF FATHER (city or town) Springfield Nebr
(State or Country)12. MAIDEN NAME OF MOTHER Nora Weaver13. BIRTHPLACE OF MOTHER (city or town) North Carolina
(State or Country)

14. Informant C E Roberts (Father)
(Address) Cloverland, Wash

15. Filed 9-1-30 J.M. Lytle
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Aug 20, 1930, to Aug 20, 1930

that I last saw him alive on Aug 20, 1930
and that death occurred, on the date stated above, at 4.55 P. m.

The CAUSE OF DEATH* was as follows:

Still Born Premature Delivery

(duration) yrs. 5 mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? none(Signed) E. J. Research M. D.Aug 19, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Clarkston, Wash Date of Burial 8/21/30 19

20. Undertaker H.R. Merchant Address Clarkston Wn

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

RECEIVED SEP 5 1930
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
COUNTY OF Oneida
City of maled
No. _____ St. _____
Registration District No. 26 State File No. 184192
(If born in hospital or institution give name.)
Prim. Registration District No. 2069 Local Registrar's No. 95
FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and {	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Aug 3</u> 19 <u>30</u> (Month) (Day) (Year)
--------------------------	---	-------	--------------------------------	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 4 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FULL NAME <u>William N. Cottrell</u>	FATHER	FULL MAIDEN NAME <u>Mary Elizabeth Mulder</u>	MOTHER
--------------------------------------	--------	---	--------

Residence (Usual place of abode) Downey, Ida.

If nonresident, give place and State _____

Color or race white Age at last Birthday 23 (Years)

Birthplace Downey, Ida. (City and State or Country)

Occupation Farmer

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 6 a. M.
on the date above stated. { Stillborn }

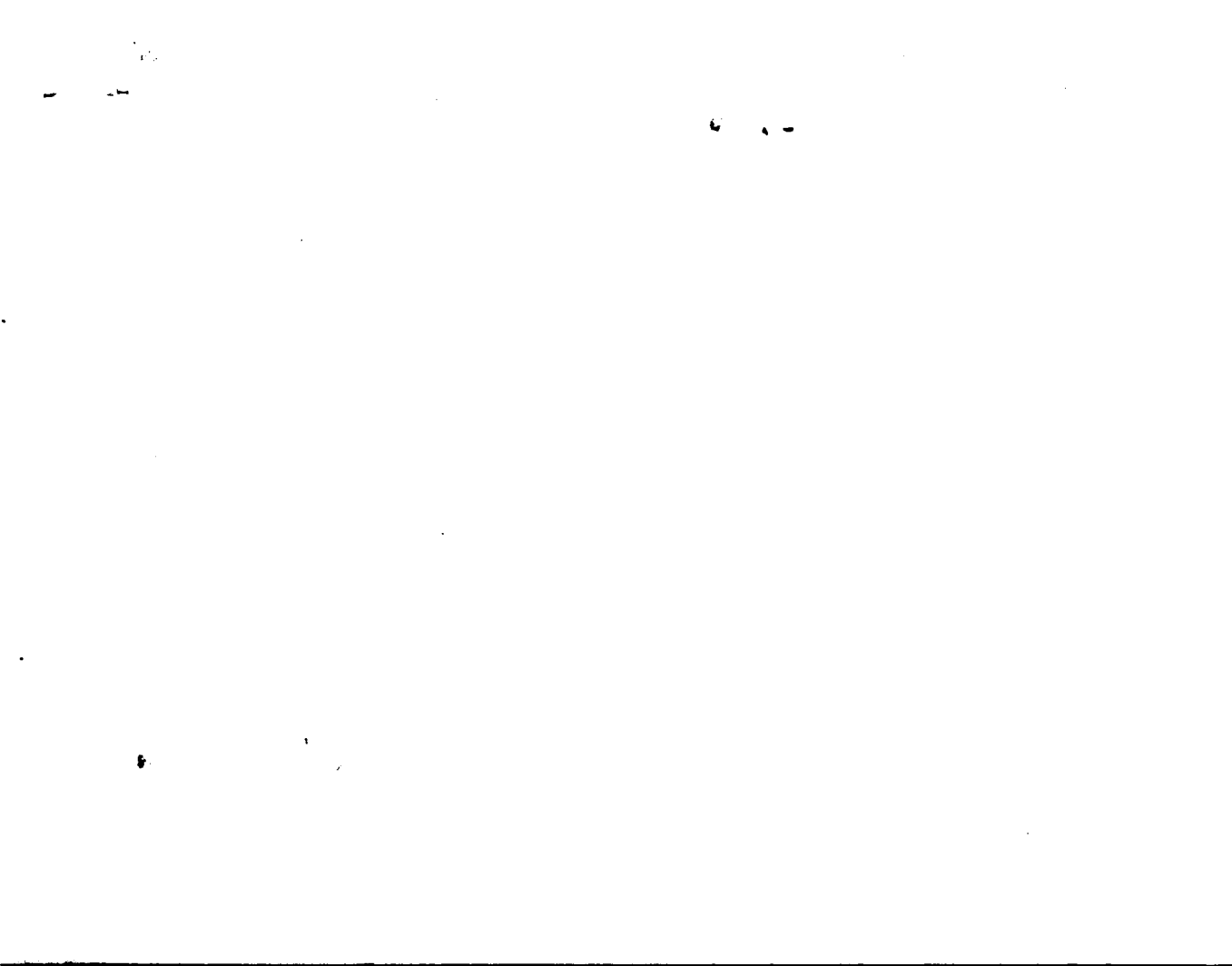
(Signature) V. P. Gust

(Physician or midwife)

Address maled, Ida.

Filed 8/31 1930 J. W. Kerns
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



N. B.—Every item of information should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECORDED SEP 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71239

PLACE OF DEATH

County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2069

Local Registrar's No. 30

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)
2. FULL NAME Stillborn (no name) Cottrell

(a) Residence. No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Child
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____
6. DATE OF BIRTH (month, day and year) Aug 2, 1930
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillborn
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (city or town) (State or country) Malad Ida
10. NAME OF FATHER Wm J Cottrell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Marsh Valley Idaho
12. MAIDEN NAME OF MOTHER May Mulder
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Regby Idaho

14. Informant Wm J Cottrell
(Address) Malad Ida
15. Filed 8/31, 1930 J. M. Arns
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 2, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from born 19____, to 19____, that I last saw him/her on Aug 2, 1930 and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:
Stillborn, head over lapping twice around neck.
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____
Did an operation precede death? _____ Date of _____
Was there an autopsy? _____

What test confirmed diagnosis? _____
(Signed) V. P. Garsst M. D.
Aug 2, 1930 (Address) Malad Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Malad Ida Date of Burial Aug 2 1930
20. Undertaker J. Guy Benson Address Malad Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Payette SEP 15 1930
City of New Plymouth
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

184198

(If born in hospital or institution
give name.)

Registration District No. 5 State File No. _____

Prim. Registration District No. 2009 Local Registrar's No. 15

FULL NAME OF CHILD Infant Darnae (Stillborn)
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Aug 30</u> 19 <u>30</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? ✓

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>Gleason McClelland Darnae</u>	MOTHER FULL MAIDEN NAME <u>Bertha Welles</u>
--	---

Residence (Usual place of abode) <u>New Plymouth, Ida.</u>	Residence (Usual place of abode) <u>with husband</u>
--	--

If non-resident, give place and State _____

Color or race <u>W</u> Age at last Birthday <u>43</u> (Years)	Color or race <u>W</u> Age at last Birthday <u>40</u> (Years)
--	--

Birthplace <u>Idaho</u> (City and State or County)	Birthplace <u>Kauai</u> (City and State or County)
---	---

Occupation <u>Farmer</u>	Occupation <u>Housewife</u>
--------------------------	-----------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 12 M.
on the date above stated.

(Signature) Wm J. Drysdale M.D.

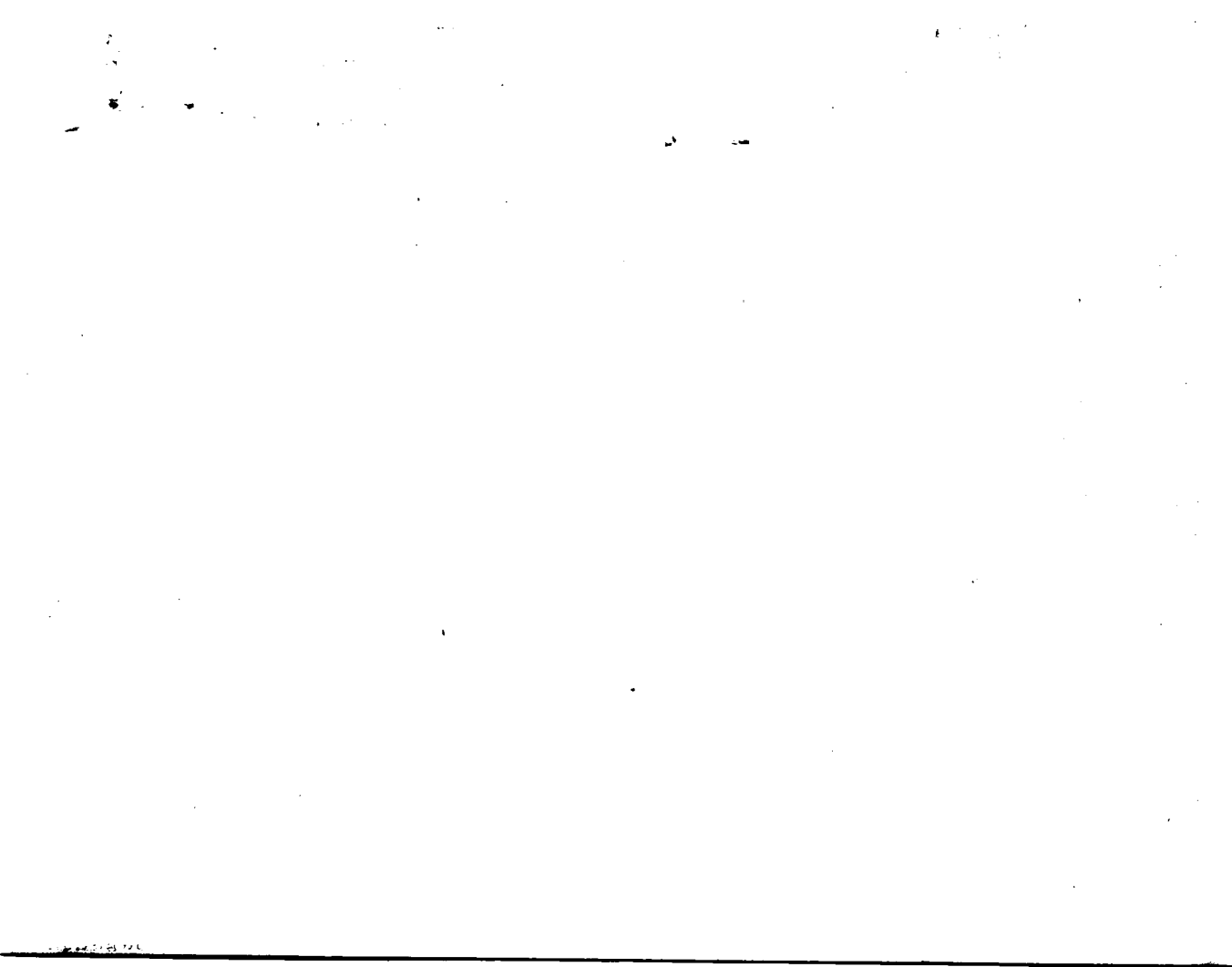
(Physician or midwife)

Address New Plymouth, Ida.

Filed Sept 1 1930 Wm J. Drysdale

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 715

PLACE OF DEATH
County of Payette
City of New Plymouth

CERTIFICATE OF DEATH

Registration District No. 5
Primary Registration District No. 2009 Local Registrar's No. 8
(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Daruall

(a) Residence. No. St.

(Usual place of abode.)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. Single, Married, Widowed, or Divorced (write the word.) ✓

5a. If married, widowed, or divorced ✓
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 30 - 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Sieelborn Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) New Plymouth, Ida
(State or country)

10. NAME OF FATHER Glenn C Daruall

11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Bertha Wells

13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant Wm J. Drysdale
(Address)

15. Filed Sept 1, 1930. Wm J. Drysdale
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 30, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from at birth, 19... to... 19...

that I last saw him alive on... 19...

and that death occurred, on the date stated above, at... m.

State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. The CAUSE OF DEATH was as follows:

Contracted maternal pelvis

..... (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

..... (duration) yrs. mos. ds.

18. Where was disease contracted ✓
if not at place of death?

Did an operation precede death? ✓ Date of...

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) Wm J. Drysdale, M. D.
Aug 30, 1930 (Address) New Plymouth

19. Place of Burial, Cremation, or Removal New Plymouth, Ida Date of Burial Aug 30 1930

20. Undertaker Doctor of child Address New Plymouth

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of (name origin);** "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County Boise
City of Ames Falls
No. Belham St.

CERTIFICATE OF BIRTH 184211

(If born in hospital or institution
give name.)

Registration District No. 25 State File No. 184211

Prim. Registration District No. 2072 Local Registrar's No. 60

FULL NAME OF CHILD Steelborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	{ and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Aug 12</u> 19 <u>30</u> (Month) (Day) (Year)
-----------------------------	---	---	--------------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? 0

Number of child of this mother, including present birth 6 (a) Born alive and now living 4

Born alive but now dead 2 Stillborn one

FATHER		MOTHER	
FULL NAME	<u>Jasper T. O'Hara</u>	FULL MAIDEN NAME	<u>Helda C. Peterson</u>
Residence (Usual place of abode)	<u>Boise Idaho</u>	Residence (Usual place of abode)	<u>Boise Idaho</u>
If non-resident, give place and State	<u>0</u>	If non-resident, give place and State	<u>0</u>
Color or race	<u>white</u>	Color or race	<u>white</u>
Age at last Birthday	<u>53</u> (Years)	Age at last Birthday	<u>42</u> (Years)
Birthplace	<u>Oregon</u> (City and State or County)	Birthplace	<u>Oregon</u> (City and State or County)
Occupation	<u>Farmer</u>	Occupation	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at - M.
on the date above stated.

(Signature) C. F. Hilley M.D.

(Physician or midwife)

Address 318

Filed 9-8 1930 Garrison Noltz
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



1

2

3

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. _____

PLACE OF DEATH

County of Power

City of American Falls, Idaho

Registration District No. 23

Primary Registration District No. 2072

(No. Bethony Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 18

2. FULL NAME Gerald O'Harra *no name (Baby O'Harra)*

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 12th 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) American Falls, Idaho
(State or country)

10. NAME OF FATHER J.T. O'Harra

11. BIRTHPLACE OF FATHER (city or town) Ore
(State or Country)

12. MAIDEN NAME OF MOTHER Hilda C. Peterson

13. BIRTHPLACE OF MOTHER (city or town) Ore
(State or Country)

14. Informant J. J. O'Harra
(Address) Roy, Idaho

15. Filed Aug 2, 1930 Gmennen Roth
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 12th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____, to 19____

that I last saw h_____ alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born child
Two weeks before gestation
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death? No

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Schick

(Signed) C. F. Schick, M. D.

Aug 12th, 1930 (Address) American Falls
Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Rockland, Idaho 8/12/30 ¹⁹

20. Undertaker

Alv. Davis American Falls
Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED SEP 4 1930 STATE OF IDAHO
County of Victor DEPARTMENT OF PUBLIC WELFARE
City of Victor BUREAU OF VITAL STATISTICS
No. 184247 St. CERTIFICATE OF BIRTH

Registration District No. 77 State File No. 184247
(If born in hospital or institution give name.) Prim. Registration District No. 2176 Local Registrar's No. 14
FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Y</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>+</u>	Date of birth <u>8/7</u> <u>1930</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? _____
Number of child of this mother, including present birth. 1 (a) Born alive and now living 3
Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>Thos. W. Cherry</u> Residence (Usual place of abode) <u>Victor, Ida. R. F. D.</u> If non-resident, give place and State _____ Color or race <u>W</u> Age at last Birthday <u>32</u> (Years) Birthplace <u>Ida</u> (City and State or County) Occupation <u>Barber</u>	MOTHER FULL MAIDEN NAME <u>Deena Hale</u> Residence (Usual place of abode) <u>Ida</u> If non-resident, give place and State _____ Color or race <u>W</u> Age at last Birthday <u>32</u> (Years) Birthplace <u>Ida</u> (City and State or County) Occupation <u>H. W.</u>
---	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 7:30 A. M.
on the date above stated. (Signature) L. R. Pape, M.D.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Driggs, Idaho
Filed 9-9- 1930 Martha Marken
Registrar.

DEPARTMENT OF COMMERCE
BUREAU OF STATISTICS
CITIZENSHIP OF BIRTH

10 210
15 210

NOTHING TO REPORT

CLINT TO BILLY LIT

(b) (7) (D)
 (b) (7) (D)
 (b) (7) (D)

What prophylactic was used to prevent Ophiolite? -

Number of child of this mother claiming present birth () born alive and now living

Both sides put you down

000000

med:134

ANTON

31/1/76

Revised: 1994-10-10

and has a big win, just as it is.

1. The first of these is the fact that the majority of the population of the United States is now living in urban areas. This is a result of the process of urbanization, which has been going on since the beginning of the 20th century. The population of the United States has increased from about 100 million in 1900 to over 200 million in 1960. At the same time, the population of rural areas has decreased from about 100 million in 1900 to about 50 million in 1960. This has led to a concentration of the population in urban areas, which has had a number of important consequences for the development of the United States.

1994

(continued on next page)

noting that

10/1/1944

DEPARTMENT OF ATTENDING PHYSICIAN OF MIDWINTER.

~~1 - 2000 - 1000~~

If

(491125-129)

(b) (5) DPP, (b) (5) ACP

45916A.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

[illegible]

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 4 1930

STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71070

PLACE OF DEATH

County of LetonCity of VictorRegistration District No. 77Primary Registration District No. 2176Local Registrar's No. 5(No. _____)
 (If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Thos. Cherry

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. Single, Married, Widowed, or Divorced (write the word)5a. If married, widowed, or divorced
 HUSBAND of _____
 (or) WIFE of _____6. DATE OF BIRTH (month, day and year) 8/7/30

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Leton Co., Victor, Ida.
 (State or country)10. NAME OF FATHER Thos. W. Cherry11. BIRTHPLACE OF FATHER (city or town) Ida.
 (State or Country)12. MAIDEN NAME OF MOTHER Lena Hatch13. BIRTHPLACE OF MOTHER (city or town) Ida.
 (State or Country)14. Informant Thos. W. Cherry
 (Address) Victor, Ida.15. Filed 9-2- 1930 Martha Marker
 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8/7 1930
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw h. _____ alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Compression of cord, in delivering after coming head. (breech case)CONTRIBUTORY (Secondary) Hydrocephalus (duration) _____ yrs. _____ mos. _____ ds.
Spina Bifida (duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? L.T.P. Pedner(Signed) 8/8 1930 (Address) Druggs, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Victor, Ida. Date of Burial 8-8-1930

20. Undertaker _____ Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

293 208-22-141
PLACE OF BIRTH RECEIVED SEP 16 1930

County of Bonneville
City of Idaho Falls, Idaho

No. L-205 Hospital St.

(If born in hospital or institution
give name.)

FULL NAME OF CHILD

Registration District No. 73 State File No. 184341

Prim. Registration District No. 2-1-1 Local Registrar's No. 238

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>August 8</u> 19 <u>30</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 0 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Roy Kellman

Residence (Usual place of abode) Moscow, Idaho

If non-resident, give place and State

Color or race White Age at last Birthday 25 (Years)

Birthplace Shaver, Kansas (City and State or County)

Occupation farmer

MOTHER
FULL MAIDEN NAME Zena Adams

Residence (Usual place of abode) Moscow, Idaho

If non-resident, give place and State

Color or race White Age at last Birthday 20 (Years)

Birthplace Idaho (City and State or County)

Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive on the date above stated. Stillborn at 4:32 A. M.

(Signature) H. Ray Hatch, M.D.
(Physician or midwife)

Address Idaho Falls, Idaho

Filed 9/13 1930 Kellman
Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

SEP 18 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock
City of Snake Falls

CERTIFICATE OF BIRTH

No. 463,104 010-653 St. 73

Registration District No. 73 State File No. 184371

(If born in hospital or institution give name.) Prim. Registration District No. 210 Local Registrar's No. 348

FULL NAME OF CHILD Eric Earl
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>Aug 4</u> 19 <u>30</u> (Month) (Day) (Year)
--------------------------	-----------------------------------	-----------------------------------	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 1 (a) Born alive and now living 1

Born alive but now dead 0 Stillborn 1

FULL NAME <u>FATHER</u> <u>Frank Earl Davis</u>	FULL MAIDEN NAME <u>MOTHER</u> <u>Vilote Fellows</u>
--	---

Residence (Usual place of abode) Snake Falls, Id. Snake Falls, Idaho

If non-resident, give place and State.

Color or race White Age at last Birthday 33 White Age at last Birthday 30
(Years) (Years)

Birthplace Dayton, Ohio Preston, Idaho
(City and State or County) (City and State or County)

Occupation Iron - Mfg. Rumburg Co. Household

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at Snake Falls, Idaho on the date above stated.

(Signature) [Signature]
(Physician or midwife)

Address Snake Falls, Idaho

Filed Aug 11 1930 [Signature] Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

REF ID: A634182

CONFIDENTIAL

TO: SAC, NEW YORK (100-388610) FROM: SAC, NEW YORK (100-388610) (P)

SUBJECT: [REDACTED] (C)

RE: [REDACTED] (C)

1. [REDACTED] (C)

2. [REDACTED] (C)

3. [REDACTED] (C)

4. [REDACTED] (C)

5. [REDACTED] (C)

6. [REDACTED] (C)

7. [REDACTED] (C)

8. [REDACTED] (C)

9. [REDACTED] (C)

10. [REDACTED] (C)

11. [REDACTED] (C)

12. [REDACTED] (C)

13. [REDACTED] (C)

14. [REDACTED] (C)

15. [REDACTED] (C)

16. [REDACTED] (C)

17. [REDACTED] (C)

18. [REDACTED] (C)

19. [REDACTED] (C)

20. [REDACTED] (C)

21. [REDACTED] (C)

22. [REDACTED] (C)

23. [REDACTED] (C)

24. [REDACTED] (C)

25. [REDACTED] (C)

26. [REDACTED] (C)

27. [REDACTED] (C)

28. [REDACTED] (C)

29. [REDACTED] (C)

30. [REDACTED] (C)

31. [REDACTED] (C)

32. [REDACTED] (C)

33. [REDACTED] (C)

34. [REDACTED] (C)

35. [REDACTED] (C)

36. [REDACTED] (C)

37. [REDACTED] (C)

38. [REDACTED] (C)

39. [REDACTED] (C)

40. [REDACTED] (C)

41. [REDACTED] (C)

42. [REDACTED] (C)

43. [REDACTED] (C)

44. [REDACTED] (C)

45. [REDACTED] (C)

46. [REDACTED] (C)

47. [REDACTED] (C)

48. [REDACTED] (C)

49. [REDACTED] (C)

50. [REDACTED] (C)

51. [REDACTED] (C)

52. [REDACTED] (C)

53. [REDACTED] (C)

54. [REDACTED] (C)

55. [REDACTED] (C)

56. [REDACTED] (C)

57. [REDACTED] (C)

58. [REDACTED] (C)

59. [REDACTED] (C)

60. [REDACTED] (C)

61. [REDACTED] (C)

62. [REDACTED] (C)

63. [REDACTED] (C)

64. [REDACTED] (C)

65. [REDACTED] (C)

66. [REDACTED] (C)

67. [REDACTED] (C)

68. [REDACTED] (C)

69. [REDACTED] (C)

70. [REDACTED] (C)

71. [REDACTED] (C)

72. [REDACTED] (C)

73. [REDACTED] (C)

74. [REDACTED] (C)

75. [REDACTED] (C)

76. [REDACTED] (C)

77. [REDACTED] (C)

78. [REDACTED] (C)

79. [REDACTED] (C)

80. [REDACTED] (C)

81. [REDACTED] (C)

82. [REDACTED] (C)

83. [REDACTED] (C)

84. [REDACTED] (C)

85. [REDACTED] (C)

86. [REDACTED] (C)

87. [REDACTED] (C)

88. [REDACTED] (C)

89. [REDACTED] (C)

90. [REDACTED] (C)

91. [REDACTED] (C)

92. [REDACTED] (C)

93. [REDACTED] (C)

94. [REDACTED] (C)

95. [REDACTED] (C)

96. [REDACTED] (C)

97. [REDACTED] (C)

98. [REDACTED] (C)

99. [REDACTED] (C)

100. [REDACTED] (C)

...and immediately was sent to prison (Philadelphia, Pennsylvania) ...

100-443887-100

[illegible][illegible]

U.S. DEPARTMENT OF AGRICULTURE

SECRET

...the ... of ...

SECRET

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

PHYSICIAN

RECEIVED SEP 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 71025

PLACE OF DEATH

County of Banner
City of _____

CERTIFICATE OF DEATH

Registration District No. 73Primary Registration District No. 214-2

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant - Davis - Christ birth.

(a) Residence. No. _____ St. _____

(Usual place of abode.)

(If nonresident give city or town and State.)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word.) —

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Aug 4 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Christ birth 0 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Dallas Texas Ede
(State or country)10. NAME OF FATHER Frank Earl Davis11. BIRTHPLACE OF FATHER (city or town) Dayton Ede
(State or Country)12. MAIDEN NAME OF MOTHER Delate Fellows13. BIRTHPLACE OF MOTHER (city or town) Preston Ede
(State or Country)14. Informant Mrs Frank Davis
(Address) Dallas Texas Ede15. Filed Aug 10 1930 W. J. Cunningham
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____
that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Christ birth - Premature birth -
later gestation 5 months

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. J. Cunningham D.
Aug 10 1930 (Address) Dallas Texas Ede

19. Place of Burial, Cremation, or Removal Date of Burial

Dallas Texas Ede Aug 4 1930

20. Undertaker Address

W. J. Cunningham

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of** (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

PLACE OF BIRTH

STATE OF IDAHO

RECEIVED OCT 14 1930 DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of BannockCity of PocatelloNo 113-109-003-219 St.Registration District No. 28File No. 184514

Hospital.....

Primary Registration District No. 2161Registered No. 9971

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of
ChildMaleTwin
Triplet
or other?

{ and }

{ Number
in order
of birth }

(To be answered only in event of plural births)

Legiti-
mate?YesDate of
birth8-9-

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?.....

Number of child of this mother, including present birth... 1.....Number of children of this mother now living, including present birth... 1.....FULL
NAMEFATHER
Cecil JacobsonFULL
MAIDEN
NAMEMOTHER
Essie May Bankhart

RESIDENCE

Pocatello

RESIDENCE

Ido-

COLOR

WhiteAGE AT LAST
BIRTHDAY22-
(Years)

COLOR

WhiteAGE AT LAST
BIRTHDAY22-
(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

La-

OCCUPATION

Service Station Prop.

OCCUPATION

Trav.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was..... at..... M.
on the date above stated.

(Residence or stillborn)

* When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

F. Smiller

(Physician or midwife)

Give names added from a supplemental report.

Address

Pocatello Idaho

Filed

10/1/1930

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

1700

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

238 112010 435 OCT 16 1930

PLACE OF BIRTH
County of Bonneville
City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 184643

No. _____ St.
Spencer Hospital Registration District No. 13 State File No. _____
(If born in hospital or institution give name.) Prim. Registration District No. 2140 Local Registrar's No. 392

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>1</u> and <u>Number in order of birth</u> <u>6</u> (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of birth <u>Sept 17</u> 19 <u>30</u> (Month) (Day) (Year)
--------------------------	---	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 6 (a) Born alive and now living 4

Born alive but now dead 0 Stillborn 2

FATHER FULL NAME <u>Antone James Schwarzenberger</u> Residence (Usual place of abode) <u>Idaho Falls</u> If non-resident, give place and State <u>Route #2</u> Color or race <u>white</u> Age at last Birthday <u>36</u> (Years) Birthplace <u>Mellins Wisconsin</u> (City and State or County) Occupation <u>rancher</u>	MOTHER FULL NAME <u>Ella May McCawin</u> Residence (Usual place of abode) <u>Idaho Falls</u> If non-resident, give place and State <u>RFD #2</u> Color or race <u>white</u> Age at last Birthday <u>36</u> (Years) Birthplace <u>Weber Canyon Utah</u> (City and State or County) Occupation _____
---	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 3¹⁰ P. M.
on the date above stated. (Signature) Arthur M. D.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Idaho Falls, Id.
Filed Sept 18 1930 Arthur M. D.

HTS-100-100-100

.....
.....
.....

CONFIDENTIAL - SECURITY INFORMATION

LET. NAMES OF CHILD

...and will not be able to do so.

[illegible]

What prophylactic was used to prevent epididymitis?

Number of child of this mother attending school with mother living

CONFIDENTIAL

HUTTON **JUNE** **MERTAN**

10-10-68

1971 Jan 10 AMT

67-1

RECEIVED 10/10/52

SECRET

100-443887-100

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific information required.

19101602/1

It is noted that there was no attempt to interview

...and while, then the latter, in a bold and

SECRET

shows that evidence of the other kind



shows other evidence of his other than child is one that neither parent nor son should make this term. A subpoena, as well as, then the father, household, and where there was no attending physician.

—The first of these is the fact that the majority of the population of the United States is now living in cities and towns of 2,500 or more people. This is a fact which has not been fully recognized by the majority of the people, and it is this fact which is the basis of the first of the two main errors of the present day. The second error is the fact that the majority of the population of the United States is now living in cities and towns of 2,500 or more people. This is a fact which has not been fully recognized by the majority of the people, and it is this fact which is the basis of the first of the two main errors of the present day.

MARGIN RESERVED FOR BINDING

184643 +

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
Exact statement of OCCUPATION is very important. See instructions on back.

PHYSICIAN

RECEIVED OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72000

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Idaho

CERTIFICATE OF DEATH
Registration District No. 73
Primary Registration District No. 2140

Local Registrar's No. 177

2. FULL NAME Paul Luth
(If death occurred in a hospital or institution, give its name instead of street and number.)
(a) Residence. No. St.
(If nonresident give city or town and State.)
Length of residence in city or town where death occurred 7 yrs. 0 mos. 0 ds. How long in U. S. if of foreign birth? 7 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.)
5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of
6. DATE OF BIRTH (month, day and year) Sept. 17, 1930
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillborn
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls
(State or country)

PARENTS
10. NAME OF FATHER Uitone James Schwarzenberger
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Watkins Wisconsin
12. MAIDEN NAME OF MOTHER Erna Mae McCowin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wesley Canyon Utah

14. Informant (Address) Pauline J. Schwarzenberger

15. Sept. 17, 1930 Confirmed
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 17, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1930, to 1930,
that I last saw him alive on 1930,
and that death occurred, on the date stated above, at 1930 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Stillborn, rammed
position of fetus

(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)
(duration) 1 yrs. 0 mos. 0 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Sept 17, 1930
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. J. Jones, M. D.
Idaho Falls, 1930 (Address)

19. Place of Burial, Cremation, or Removal Dicks Falls Id Date of Burial Sept 17 1930

20. Undertaker none Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Saleman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile Factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At Home**, and children not gainfully employed, as **At school or At Home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report **Typhoid pneumonia**); **Lobar Pneumonia**; **Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.**, **Carcinoma, Sarcoma, etc.**, of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bonner
City of Isaiah Falls
No. 205 Hospital

OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

184655

Registration District No. 23 State File No. _____
Prim. Registration District No. 23 Local Registrar's No. 404
(If born in hospital or institution give name.)

FULL NAME OF CHILD Still born Cook
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>1</u> and <u>1</u> Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Sept 10</u> 19 <u>30</u> (Month) (Day) (Year)
--------------------------	--	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth. 13 (a) Born alive and now living 12
Born alive but now dead 12 Stillborn 1

FULL NAME FATHER <u>Jas Ed Cook</u>	FULL MAIDEN NAME MOTHER <u>Christina M Bushmiller</u>
Residence (Usual place of abode) <u>Isaiah Falls RI #5</u>	Residence (Usual place of abode) <u>RI #5</u>

If non-resident, give place and State _____	If non-resident, give place and State _____
Color or race <u>white</u> Age at last Birthday <u>49</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>45</u> (Years)
Birthplace <u>Sevier Co Utah</u> (City and State or County)	Birthplace <u>Roxbury</u> (City and State or County)
Occupation <u>farmer</u>	Occupation <u>doctor</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 7⁰³ 9 A. M. on the date above stated.

(Signature) _____

(Physician or midwife)

Address Isaiah Falls

Filed Sept 13 1930 _____

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

[illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72015

PLACE OF DEATH
County of Bonneville
City of Idaho Falls, Ida.

Registration—District No. _____

Primary Registration District No. _____

(No. L.O.S. Hospital)Local Registrar's No. 173

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn Cook(a) Residence. No. Idaho Falls St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

newborn

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day and year) Sept 10 1930

7 AGE

Years

Months

Days

1 If LESS than
day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Idaho Falls, Ida
(State or country)

10 NAME OF FATHER

J. C. Cook11 BIRTHPLACE OF FATHER (city or town)
(State or country)Idaho Falls, Ida

12 MAIDEN NAME OF MOTHER

Christina M. Buchmiller13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Idaho Falls, Ida14 Informant J. C. Sanchez (Cynthia Wint.)
(Address) Idaho Falls15 Filed Sept 14, 1930 W. J. Wint.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept101930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1930, to Sept 10, 1930,that I last saw him alive on Sept 10, 1930,and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows:

Perinatal Hemorrhage
Premature separation7 (duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)death 2 days before birth
(duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date of _____Was there an autopsy? NoWhat test confirmed diagnosis? Examination of Placenta

(Signed)

1/101930

(Address)

Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Grant, Ida, 11Sept. 1930

20. Undertaker

Jack A. Wood

Address

Idaho Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF RECEIVED OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

County of Bonneville
City of Idaho Falls
No. 518-220-010-363 St.

L. D. S. Hospital
(If born in hospital or institution
give name.)

Registration District No. State File No. 184668

Prim. Registration District No. Local Registrar's No. 432

FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>7</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Sept. 20</u> (Month) (Day) (Year) <u>1930</u>
-----------------------	---	-----	--------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth. 1 (a) Born alive and now living.

Born alive but now dead. Stillborn

FATHER		MOTHER	
FULL NAME <u>Ray Nabra</u>	FULL MAIDEN NAME <u>Sue Mae Toliver</u>		
Residence (Usual place of abode) <u>Idaho Falls, Idaho</u>	Residence (Usual place of abode) <u>Idaho Falls, Idaho</u>		
If non-resident, give place and State	If non-resident, give place and State		
Color or race <u>W.</u> Age at last Birthday <u>43</u> (Years)	Color or race <u>W.</u> Age at last Birthday <u>43</u> (Years)		
Birthplace <u>Syria</u> (City and State or County)	Birthplace <u>Farber Missouri</u> (City and State or County)		
Occupation <u>Prop. of shoe store</u>	Occupation <u>housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 10 15 P. M.
on the date above stated.
(Signature) A. H. Wilson M.D.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address Idaho Falls Idaho

Filed Sept 23 1930 A. H. Wilson
Registrar

NOTHING IS IMPOSSIBLE

Chief Executive Officer

(180 V)

1941

УДК 62-50.01:621.372.6.01+621.372.6.01

(အကျဉ်းချုပ်)

६२११३

RECEIVED AT THE OFFICE OF THE ATTORNEY GENERAL
JAN 10 1940

184668 *

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71999

PLACE OF DEATH

County of Bonanza
City of Idaho Falls

Registration District No. 23

Primary Registration District No. 214-0

Local Registrar's No. 176

(No. 100 S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Louise Nahra

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred, 10 mos. 10 yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Female 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 20 - 1930

7. AGE Years 0 Months 0 Days 0 If LESS than 1 day, hrs. or

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls (State or country) Ida.

10. NAME OF FATHER Ray Nahra

11. BIRTHPLACE OF FATHER (city or town) Syria (State or Country)

12. MAIDEN NAME OF MOTHER Sue Mae Folliver

13. BIRTHPLACE OF MOTHER (city or town) Missouri (State or Country)

14. Informant Ray Nahra (Address) Idaho Falls, Ida.

15. Registered 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 20 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1930, to Sept 20, 1930 that I last saw him alive on Sept 20, 1930

and that death occurred, on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Stillborn - Premature Mother threatened with eclampsia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Wilson M. D. 9/20/30 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls, Ida. 9/21 1930 Date of Burial

20. Undertaker J. F. M. Van Idaho Falls, Idaho Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Challis RECEIVED SEP 24 1930City of ChallisNo. 292.023.019.729 St.(If born in hospital or institution
give name.)FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 128 State File No. 184774Prim. Registration District No. 2186 Local Registrar's No. 204

Sex of Child	Twin Triplet or other?	{ and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth	Month	Day	Year
	(To be answered only in event of plural births)			<u>July</u>	<u>23</u>		<u>1930</u>

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 9 (a) Born alive and now living 2Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>Charles Elmer Bishop</u>	MOTHER FULL MAIDEN NAME <u>Laura Helma Phillips</u>
---	--

Residence (Usual place of abode) Challis, Idaho

If non-resident, give place and State

Color or race White Age at last Birthday 43 (Years)Birthplace New London Iowa (City and State or County)Occupation Rancher

If non-resident, give place and State

Color or race White Age at last Birthday 26 (Years)Birthplace Idaho Falls (City and State or County)Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 1 A. M.
on the date above stated.(Signature) C. L. Kirtley M.D.

(Physician or midwife)

Address Challis, IdahoFiled Aug 23, 1930 Pharm. M. Kennedy
Registrar

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 11-11-2000 BY 60322 UCBAW/STP

STATE OF NEW YORK

IN SENATE,
January 1, 1914.
REPORT
OF THE
COMMISSIONER OF THE DEPARTMENT OF HEALTH,
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
JANUARY 1, 1914.

ALBANY:
JANUARY 1, 1914.

PRINTED BY THE
STATE OF NEW YORK.

WHEREAS there was an attending physician
at the time of the birth of the child, who was
born on the 1st of January, 1914.

REPORT

IN SENATE,
January 1, 1914.
REPORT
OF THE
COMMISSIONER OF THE DEPARTMENT OF HEALTH,
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
JANUARY 1, 1914.

ALBANY:
JANUARY 1, 1914.

PRINTED BY THE
STATE OF NEW YORK.

WHEREAS there was an attending physician
at the time of the birth of the child, who was
born on the 1st of January, 1914.

184774 +
 RECEIVED SEP 24 1930

STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 72049

PLACE OF DEATH

County of Custer
 City of Challis

CERTIFICATE OF DEATH

Registration District No. 108

Primary Registration District No. 3186

Local Registrar's No. 107

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillbirth

(a) Residence. No. St.

(Usual place of abode.)

Length of residence in city or town where death occurred. yrs. mos. ds.

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
 HUSBAND of
 (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 23 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work 4th mo gestation

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Challis, Idaho
 (State or country)

10. NAME OF FATHER Charles Elmer Bishop

11. BIRTHPLACE OF FATHER (city or town) New London
 (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Laura Philma Philps

13. BIRTHPLACE OF MOTHER (city or town) Idaho Falls
 (State or County) Idaho

14. Informant Laura Philma Bishop
 (Address)

15. Filed Aug 23, 1930 Elaine M. Kennedy
 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 23, 1930
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 18, 1930, to July 23, 1930
 that I last saw him alive on

and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. THE CAUSE OF DEATH was as follows:

Cause not known.

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. J. Hartley M.D.

19. (Address) Challis, Idaho

19. Place of Burial, Cremation, or Removal

Date of Burial

Challis, Idaho July 23 1930

20. Undertaker

Address

Relatives Challis, Idaho

MARGIN RESERVED FOR BINDING
 WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
 Exact statement of OCCUPATION is very important. See instructions on back.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of** (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

165-206 027:557
PLACE OF BIRTH
RECEIVED OCT 10 1930
County of Jerome
City of Jerome
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 184873

Registration District No. 18 State File No. _____
Local Registrar's No. _____
Prim. Registration District No. _____

FULL NAME OF CHILD Chana Gomez
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>2</u> and <u>1</u>	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Sept 6</u> 19 <u>30</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? 20% Argol

Number of child of this mother, including present birth 11 (a) Born alive and now living 8

Born alive but now dead 2 Stillborn 1

FATHER FULL NAME <u>Donaciano Gomez</u>	MOTHER FULL MAIDEN NAME <u>Augustina Yegrete</u>
--	---

Residence (Usual place of abode) <u>Jerome Idaho</u>	Residence (Usual place of abode) <u>Jerome Idaho</u>
--	--

It non-resident, give place and State _____	It non-resident, give place and State _____
---	---

Color or race <u>Brown</u> Age at last Birthday <u>42</u> (Years)	Color or race <u>Brown</u> Age at last Birthday <u>40</u> (Years)
---	---

Birthplace <u>Mexico</u> (City and State or County)	Birthplace <u>Mexico</u> (City and State or County)
---	---

Occupation <u>Laborer</u>	Occupation <u>House wife</u>
---------------------------	------------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

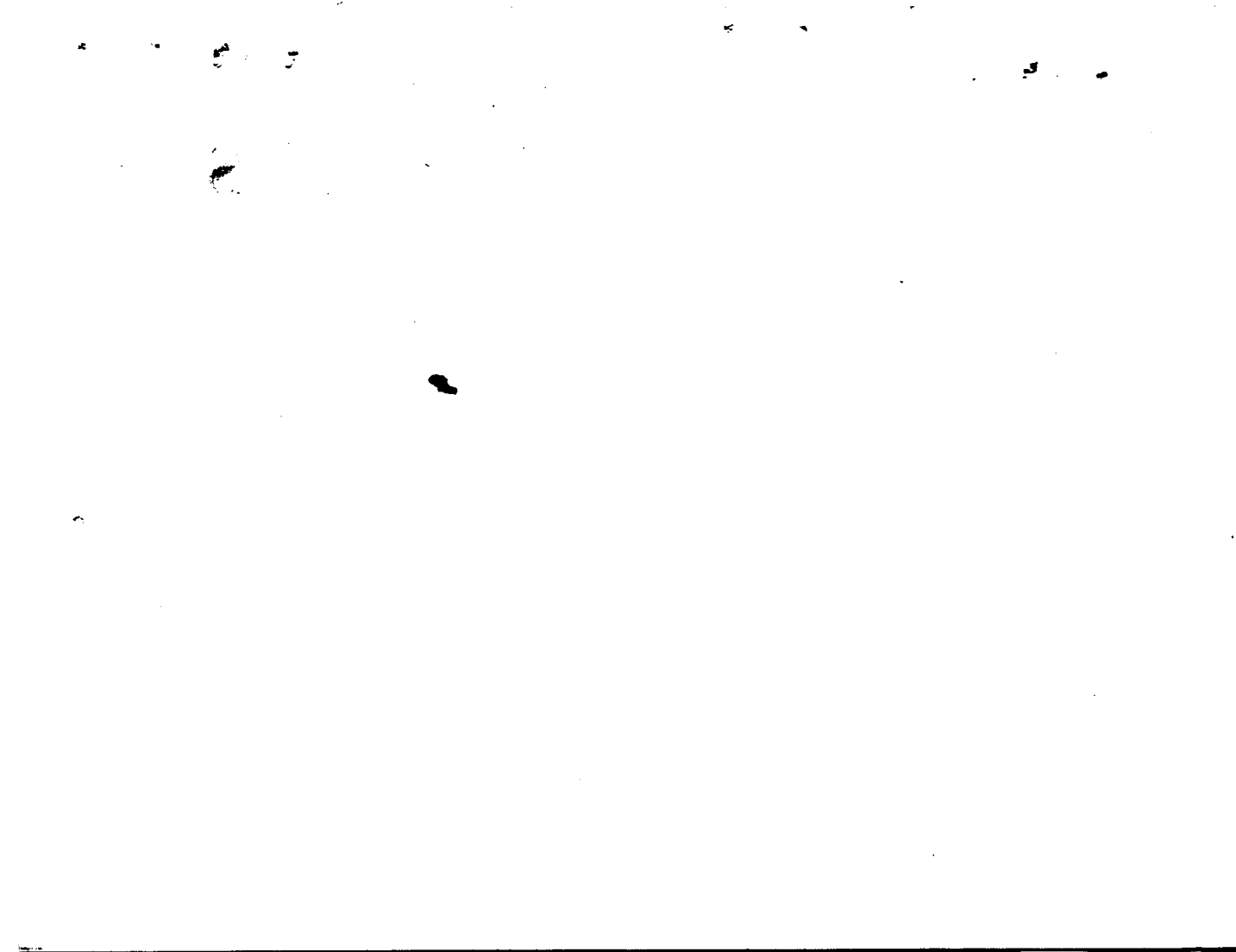
I hereby certify that I attended the birth of this child, who was Stillborn at 1:30 P. M.
on the date above stated.

(Signature) Chas F. Zeller
M.D.
(Physician or midwife)

Address Jerome Idaho

Filed 9/7 1930 Chas F. Zeller
Reg. Str.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED NOV 7 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho OCT 27 1930

184873

Mrs. D. Gomez
Jerome

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD

Chana Gomez

PLACE OF
BIRTH

Jerome

DATE OF
BIRTH

Sept. 8, 1930

SEX OF
CHILD

Female

1. Number of children born to this mother, including present birth 10
2. Number born alive and now living 7
3. Born alive but now dead 3
4. Number of children stillborn none

(Please write plainly)

Information with reference to

FATHER

Donaciano Gomez
(Full name)

P.O. Box 434
(Residence)

Age at last birthday 42

Canadas Jalisco Mexico
(Birthplace)

Laborer
(Occupation)

Information with reference to

MOTHER

Agustina Negrete
(Full maiden name)

P.O. Box 434
(Residence)

Age at last birthday 38

Leon Jalisco Mexico
(Birthplace)

is none

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C. K. Macey
C.K. Macey

Special Agent, Bureau of the Census.

1. The first part of the document is a list of names and addresses of the members of the committee.

2. The second part of the document is a list of names and addresses of the members of the committee.

3. The third part of the document is a list of names and addresses of the members of the committee.

4. The fourth part of the document is a list of names and addresses of the members of the committee.

5. The fifth part of the document is a list of names and addresses of the members of the committee.

6. The sixth part of the document is a list of names and addresses of the members of the committee.

7. The seventh part of the document is a list of names and addresses of the members of the committee.

8. The eighth part of the document is a list of names and addresses of the members of the committee.

9. The ninth part of the document is a list of names and addresses of the members of the committee.

10. The tenth part of the document is a list of names and addresses of the members of the committee.

WHITE PLAIN, WITH UNFADING LINK—LEAD AS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72074

PLACE OF DEATH

County of Jerome

City of Jerome

Registration District No. 18

Primary Registration District No.

Local Registrar's No.

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Gomez

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Mexican 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 6/30

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

10. NAME OF FATHER Donaciano Gomez

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mexico

12. MAIDEN NAME OF MOTHER Augustina Regrete

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mexico

14. Informant Donaciano Gomez (Address) Jerome, Idaho

15. Filed 9/6/30 C. D. Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 6 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 6 1930 to Sept. 6 1930 that I last saw him alive on Sept. 6 1930 and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

asphyxia due to fracture of ribcage with lodging of after coming head (duration) _____ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) C. D. Zeller M. D. 9/6/30 (Address) Jerome, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Jerome, Idaho Date of Burial 9/6 1930

20. Undertaker Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO	
County of <u>Latah</u>	SEP 29 1930	DEPARTMENT OF PUBLIC WELFARE	
City of <u>Deary</u>		BUREAU OF VITAL STATISTICS	
No. _____	St. _____	CERTIFICATE OF BIRTH	
<u>155-215 029 494</u>		Registration District No. <u>65</u>	State File No. <u>S 184917</u>
(If born in hospital or institution give name.)		Prim. Registration District No. <u>2145</u>	Local Registrar's No. _____
FULL NAME OF CHILD <u>Joan Avery Baby Avery (Stillborn)</u>			
(If stillborn, substitute the word "Stillbirth" for name of child)			
Sex of Child <u>Female</u>	Twin <u>Triplet</u> or other? <u>and</u>	Legitimate? <u>yes</u>	Date of birth <u>Aug 15</u> 19 <u>30</u>
	(To be answered only in event of plural births)		(Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? _____			
Number of child of this mother, including present birth <u>3</u> (a) Born alive and now living <u>2</u>			
Born alive but now dead <u>x</u> Stillborn <u>1</u>			
FATHER		MOTHER	
FULL NAME <u>Charles Avery</u>	FULL MAIDEN NAME <u>Bernadine Drury</u>		
Residence (Usual place of abode) <u>Deary</u>	Residence (Usual place of abode) <u>Deary</u>		
If nonresident, give place and State _____	If nonresident, give place and State _____		
Color or race <u>white</u> Age at last Birthday <u>29</u>	Color or race <u>white</u> Age at last Birthday <u>22</u>		
(Years)	(Years)		
Birthplace <u>Michigan</u>	Birthplace <u>Idaho</u>		
(City and State or Country)	(City and State or Country)		
Occupation <u>Blacksmith</u>	Occupation <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 10:30 P. M. on the date above stated.

(Signature) D. J. C. Gibson

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife) _____

Address Pottatch

Filed Aug 30 1930 G. M. Thompson Registrar.

2. 1. 1.

2.

2. 1. 1.

RECEIVED NOV 19 1930

FORM V. S. NO. 27B.

5M-12-1

STATE OF IDAHO

BOARD OF HEALTH--BUREAU OF VITAL STATISTICS

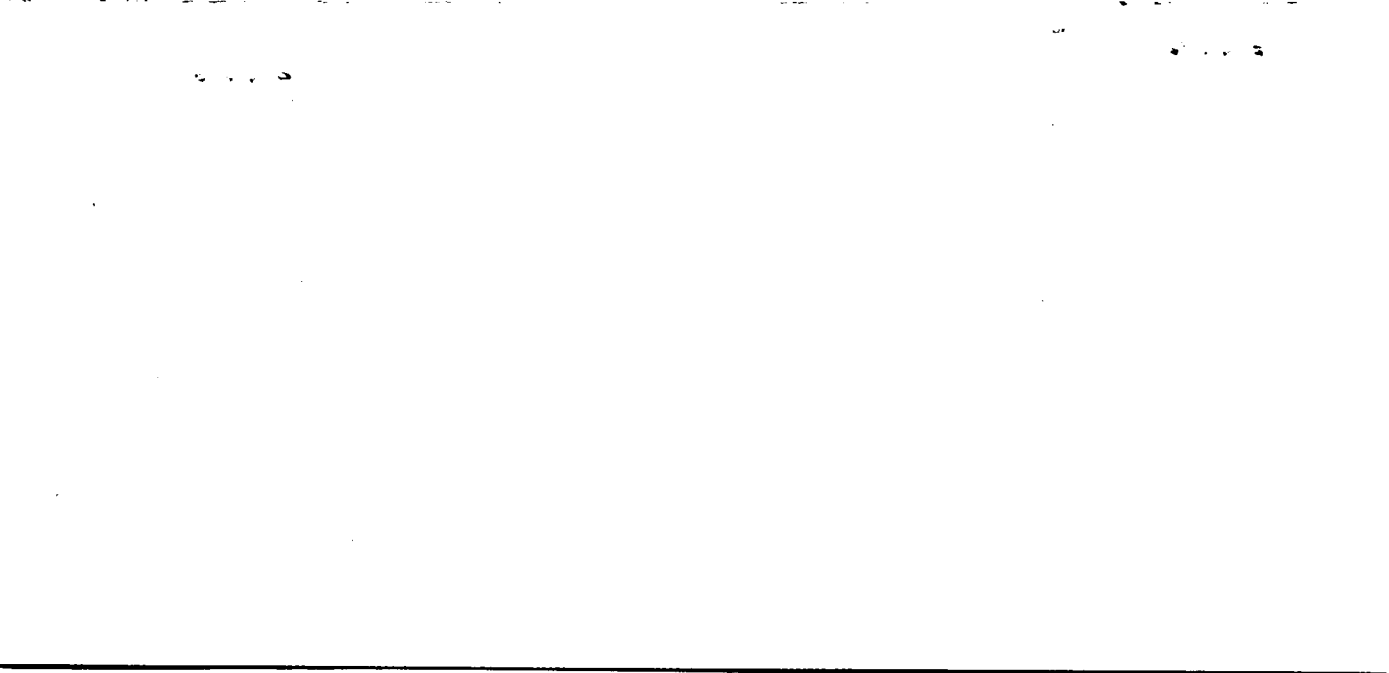
SUPPLEMENTAL REPORT OF BIRTH

Place of Birth { City Deary Registered No. 65
 Street and House No. _____
 County Latah Registration Dist. No. 2145

Sex of Child Female
 Date of Birth Aug 15 1930
MONTH DAY YEAR
 Father Charles Avery
FULL NAME
 Mother Bernadine O. Drury
FULL MAIDEN NAME

I Hereby Certify that the child described herein
 has been named:

Joan Avery
GIVEN NAME IN FULL SURNAME
 as reported by Mrs Charles Avery
FATHER OR MOTHER
Dr J. W. Thompson
LOCAL REGISTRAR



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

396-218-029-795
PLACE OF BIRTH IS OCT 14 1930
County of Latah
City of Moscow

No. 220 S. Main St.

The Gateman
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 184941

Registration District No. 61 State File No. 1011

Prim. Registration District No. 1011 Local Registrar's No. 1011

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Sept 18</u> (Month) (Day) (Year) <u>1930</u>
----------------------------	---	--------------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME Alton Douglas Crowe
Residence (Usual place of abode) Grangeville Idaho

If nonresident, give place and State Idaho

Color or race White Age at last Birthday 30 (Years)

Birthplace Grangeville Idaho (City and State or Country)

Occupation Cowboy

MOTHER
FULL MAIDEN NAME Bella Green
Residence (Usual place of abode) Grangeville Idaho

If nonresident, give place and State Idaho

Color or race White Age at last Birthday 27 (Years)

Birthplace Moscow Idaho (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

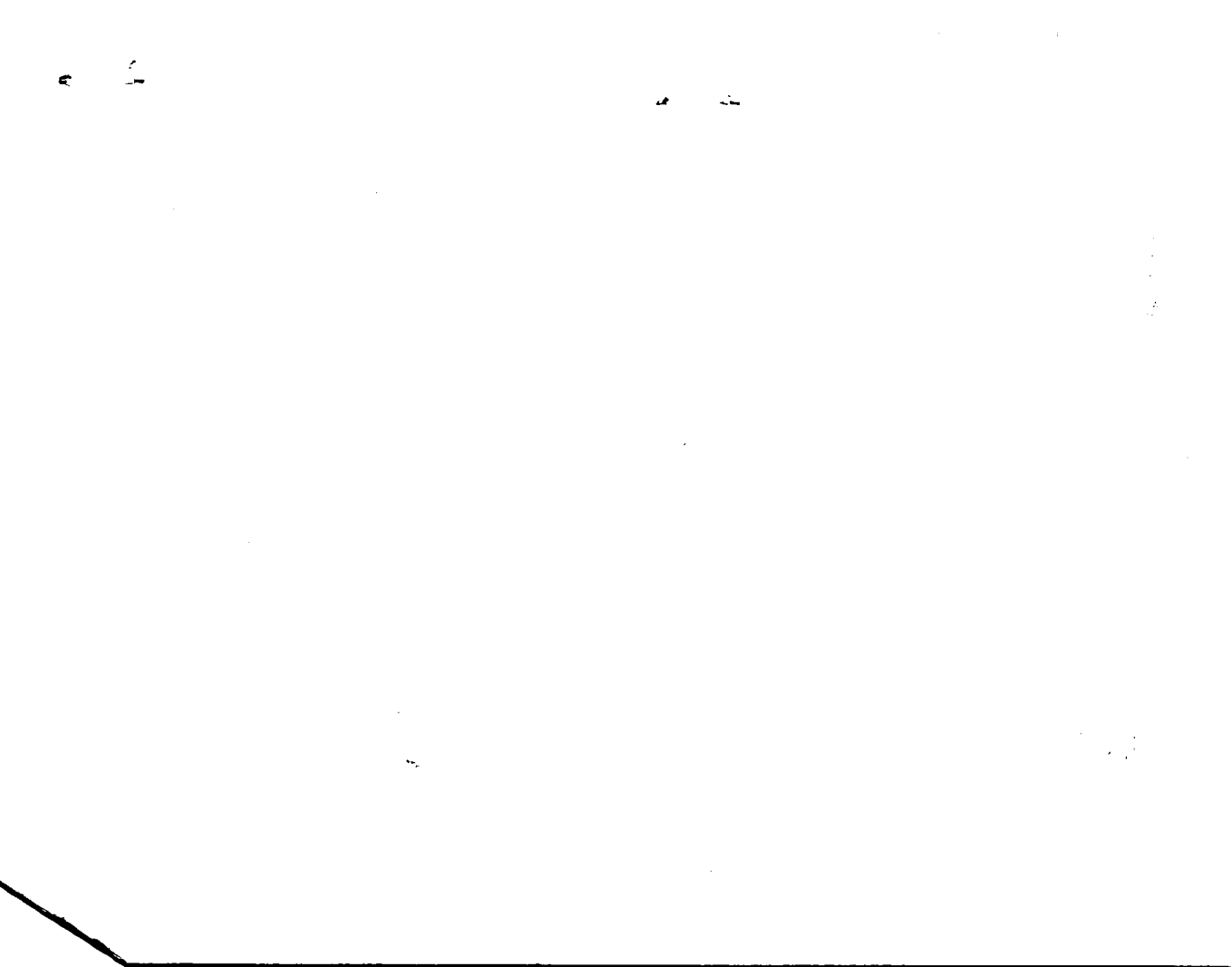
I hereby certify that I attended the birth of this child, who was Born alive at 9:15 a. M. on the date above stated.
(Signature) Chas. H. Gateman

(Physician or midwife)

Address Moscow Idaho

Filed 10/9 1930

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72104

PLACE OF DEATH

Latah

County of

City of MoscowRegistration District No. 61Primary Registration District No. 1011Local Registrar's No. 407

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME (Still Born) Baby Crowe

(a) Residence. No. St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. Single, Married, Widowed,
or Divorced (write the word)White5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years

Months

Days

If LESS than 1 day,
hrs. or
min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)

10. NAME OF FATHER

Alton Crowe11. BIRTHPLACE OF FATHER (city or town)
(State or Country)Idaho Grangeville

12. MAIDEN NAME OF MOTHER

Della Green13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)Moscow Idaho

14.

Informant
(Address)Alton Crowe
Grangeville Idaho

15.

Filed

, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 18 1930

(Month)

(Day)

19
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 18 1930 to Sept 18 1930that I last saw er xxx Stillborn 19and that death occurred, on the date stated above, at 9:15 A.m.

The CAUSE OF DEATH* was as follows:

Abortion 3rd month

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Peritonitis.

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? -- Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Chris L. Gritman

M. D.

Sept 20, 1930 (Address) Moscow, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Moscow9/21/30

20. Undertaker

Address

R. M. GrimMoscow, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

PARENTS

184441 A

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of Minidoka
City of Paul, Ida

No. RV 1 St.
296-107-034-349
(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 19 State File No. 184999
Prim. Registration District No. 2013 Local Registrar's No. 150

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Aug 7</u> 1930 (Month) (Day) (Year)
-----------------------------	---	---	--------------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 10 (a) Born alive and now living 7

Born alive but now dead _____ Stillborn _____

FATHER		MOTHER	
FULL NAME <u>John Broadhead</u>	FULL MAIDEN NAME <u>Etta Cuntas</u>		
Residence (Usual place of abode) <u>Paul</u>	Residence (Usual place of abode) <u>Paul</u>		
If non-resident, give place and State <u>Ida</u>	If non-resident, give place and State <u>Ida</u>		
Color or race <u>w</u> Age at last Birthday <u>61</u> (Years)	Color or race <u>w</u> Age at last Birthday <u>41</u> (Years)		
Birthplace <u>Savoy Utah</u> (City and State or County)	Birthplace <u>Aurora Utah</u> (City and State or County)		
Occupation <u>farmer</u>	Occupation <u>housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 5 45 P. M.
on the date above stated.

(Signature) Leland Trappier, M.D.
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Rupert, Ida
Filed 9-12-1930 E. B. Blum
Registrar.

1. I hereby certify that the child named above was born to the mother named above at the place and date stated on the birth record on file in the office of the Registrar of Births and Deaths, and that the child is now living.

2. I hereby certify that the child named above was born to the mother named above at the place and date stated on the birth record on file in the office of the Registrar of Births and Deaths, and that the child is now living.



3. I hereby certify that the child named above was born to the mother named above at the place and date stated on the birth record on file in the office of the Registrar of Births and Deaths, and that the child is now living.

4. I hereby certify that the child named above was born to the mother named above at the place and date stated on the birth record on file in the office of the Registrar of Births and Deaths, and that the child is now living.

5. I hereby certify that the child named above was born to the mother named above at the place and date stated on the birth record on file in the office of the Registrar of Births and Deaths, and that the child is now living.

6. I hereby certify that the child named above was born to the mother named above at the place and date stated on the birth record on file in the office of the Registrar of Births and Deaths, and that the child is now living.

7. I hereby certify that the child named above was born to the mother named above at the place and date stated on the birth record on file in the office of the Registrar of Births and Deaths, and that the child is now living.

8. I hereby certify that the child named above was born to the mother named above at the place and date stated on the birth record on file in the office of the Registrar of Births and Deaths, and that the child is now living.

9. I hereby certify that the child named above was born to the mother named above at the place and date stated on the birth record on file in the office of the Registrar of Births and Deaths, and that the child is now living.

STATE OF IDAHO

RECEIVED SEP 6 1930

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 71789

PLACE OF DEATH

County of MinidokaCity of Paul

CERTIFICATE OF DEATH

Registration District No. 19Primary Registration District No. 2015

(No.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Broadhead

(a) Residence. No.

St.

(Usual place of abode.)

Length of residence in city or town where death occurred yrs.

mos.

ds.

How long in U. S. if of foreign birth? yrs.

mos.

ds.

(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. Single, Married, Widowed,
or Divorced (write the word.)Single

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Aug. 7 1930

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or
min.Still Born

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)PaulIdaho

10. NAME OF FATHER

Jabez Broadhead11. BIRTHPLACE OF FATHER (city or town)
(State or Country)Utah

12. MAIDEN NAME OF MOTHER

Etta Curtis13. BIRTHPLACE OF MOTHER (city or town)
(State or County)Utah

14.

Informant
(Address)

15.

Filed Aug 11 1930

Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug. 7 1930

(Month)

(Day)

19...
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 7 1930, to Aug 7 1930
that I last saw him stillborn Aug 7 1930
and that death occurred on the date stated above, at 8 Pm.*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:HydrocephalusPre-natal

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert H. Johnson, M. D.19... (Address) Robert H. Johnson

19. Place of Burial, Cremation, or Removal

Heyburn Ida

Date of Burial

Aug. 8 1930

20. Undertaker

Address

R. E. Johnson Burley

PARENTS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

PHYSICIAN

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) SALEMAN, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid House-keepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of** (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

413-204035-132

PLACE RECORDED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of *Payson*
City of *Payson*No. _____ St. _____ Registration District No. *96* File No. *185017*Hospital _____ Primary Registration District No. *1009* Registered No. _____FULL NAME OF CHILD *Cora Katherine Mathews*
(Certificate of no value without full name of child.)

Sex of Child <i>Female</i>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <i>yes.</i>	Date of birth. <i>9-4-1930</i> (Month) (Day) (Year)
-------------------------------	---	-----	--------------------------------	---------------------------------	---

What bactericidal solution was used in eyes? *20 To Argysol*Number of child of this mother, including present birth. *1* Number of children of this mother now living, including present birth. *0*FATHER
FULL NAME *Joseph Eugene Mathews*
RESIDENCE *Payson, Wash.*COLOR *White* AGE AT LAST BIRTHDAY *29* (Years)BIRTHPLACE *Oklahoma*OCCUPATION *Laborer*MOTHER
FULL MAIDEN NAME *Nellie Atkinson*
RESIDENCE *Payson, Wash.*COLOR *White* AGE AT LAST BIRTHDAY *20* (Years)BIRTHPLACE *Wash. Canada*OCCUPATION *House wife*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was *stillborn*, at *145* M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *H. Ponae, M.D.*
Lerviston, Ida.
(Physician or midwife)

Give names added from a supplemental report.

Address *Payson, Ida.*
Filed *10-7-1930* *J. M. Lyle*
Registrar.

N. B.—In case of more than one child, give the number of each.



1. 1

1. 1

1. 1

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72138

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 46
Primary Registration District No. 1829

Local Registrar's No. Hand Rouse

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bora Catherine Mathews
(a) Residence. No. Anatone Ave. St. Anatone Ave.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OF RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Sept 4, 1930
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillbirth
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston (State or country) Idaho
10. NAME OF FATHER J. E. Mathews
11. BIRTHPLACE OF FATHER (city or town) Okla. (State or Country)
12. MAIDEN NAME OF MOTHER Mell Atkinison
13. BIRTHPLACE OF MOTHER (city or town) Canada (State or Country)

14. Informant J. E. Mathews (Address) Anatone Ave.
15. Filed Sept 5, 1930 J. M. Lytle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 4, 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 9-4-30, 1930, to 9-4-30, 1930, that I last saw him alive on 9-4-30, 1930, and that death occurred, on the date stated above, at 9-4-30 m. The CAUSE OF DEATH* was as follows:
Stillbirth
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Signs
(Signed) H. Rouse M.D.
9-5-30, 1930 (Address) Lewiston, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
19. Place of Burial, Cremation, or Removal Lewiston Idaho Date of Burial 9/4 1930
20. Undertaker Brooks Harry Address Lewiston Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT
N. B.—In case of more than one child at birth a SEPARATE RETURN must be
each and the number of each, in order of birth stated.

PLACE OF BIRTH

OCT 7 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Quincy
City of Malad
No. 693-130-035-693 St.

Community Hospital
(If born in hospital or institution
give name.)

Registration District No. 26 State Idaho
Prim. Registration District No. 2069 Local Registrar's No. 113

FULL NAME OF CHILD

Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate?	Date of birth <u>Sept 30</u> 19 <u>30</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------	------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? Angelol

Number of child of this mother, including present birth 5 (a) Born alive and now living 5

Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>William J. Williams</u>	MOTHER FULL MAIDEN NAME <u>Lerada E. Williams</u>
--	--

Residence (Usual place of abode) Malad

If nonresident, give place and State

Color or race white Age at last Birthday 46 (Years)

Birthplace Idaho (City and State or Country)

Occupation Laborer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive
on the date above stated. Stillborn at 8:15 P. M.

(Signature) [Signature]
Physician
(Physician or midwife)

Address Malad, Ida.

Filed 9/30 1930 J. M. Kern

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE **RECEIVED** OCT 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

185146

County of Idaho
City of Victor

No. 231713 St. 041363

(If born in hospital or institution
give name.)

Registration District No. 77 State File No. 185146

Prim. Registration District No. 2176 Local Registrar's No. 31

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and <u> </u>	Number in order of birth <u> </u>	Legiti- mate? <u>yes</u>	Date of birth <u>9-13-1930</u>
(To be answered only in event of plural births)				(Month)	(Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 6 (a) Born alive and now living 4

Born alive but now dead 1 Stillborn 1

FULL NAME <u>W. F. Blanchard</u>	FATHER	FULL MAIDEN NAME <u>Blady's Battrell</u>	MOTHER
----------------------------------	--------	--	--------

Residence (Usual place of abode) Victor

If non-resident, give place and State

Color or race W Age at last Birthday 35 (Years)

Birthplace Victor Idaho (City and State or County)

Occupation farmer

Color or race W Age at last Birthday 29 (Years)

Birthplace Payson Utah (City and State or County)

Occupation farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. 12 P. M.

(Signature) G. J. Harrison

Phys
(Physician or midwife)

Address Driggs Idaho

Filed 10-4-1930 Martha Marker

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

1-1-1918

Registration District No. 28 State File No.

Birth Registration District No. 28 State File No.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

At witness, appearing in the birth certificate, the name of child.

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

Where there was no attending physician or midwife then the father, householder or other person present at the birth of the child is one that makes provision for the child's care and support.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72172

PLACE OF DEATH

County of IdahoCity of Victor

Registration District No.

Primary Registration District No.

Local Registrar's No. 7

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William(a) Residence. No. Victor, Ida. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) single5a. If married, widowed, or divorced
HUSBAND of ☒
(or) WIFE of ☒6. DATE OF BIRTH (month, day and year) 9-13-19307. AGE Years Months Days If LESS than 1 day, hrs. or min.
2 10 10 10 10 10

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. ☒(b) General nature of industry, business, or establishment in which employed (or employer) ☒(c) Name of employer ☒9. BIRTHPLACE (city or town) Victor, Ida.
(State or country)10. NAME OF FATHER Wallace Fife Blanchard11. BIRTHPLACE OF FATHER (city or town) Victor, Ida.
(State or Country)12. MAIDEN NAME OF MOTHER Bladys Central13. BIRTHPLACE OF MOTHER (city or town) Salt Lake, Utah
(State or Country)14. Informant Wallace F. Blanchard
(Address) Victor, Ida.15. Filed 10-4-, 1930 Martha Marker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 13 1930
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Sept 13, 1930, to Sept 13, 1930
that I last saw him alive on Sept 13, 1930
and that death occurred, on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Anal formation
hemorrhoids

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Parkison, M.D.
9-14-, 1930 (Address) Victor, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Victor, Ida Date of Burial 9-14-1930

20. Undertaker Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

168-211-041-396

PLACED ON FILED OCT 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

185151

County of Teton
City of Clementsville
No. _____ St. _____

CERTIFICATE OF BIRTH

Registration District No. 77 State File No. _____
(If born in hospital or institution give name.) Prim. Registration District No. 2176 Local Registrar's No. 96

FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>9-11-1930</u> (Month) (Day) (Year)
----------------------------	------------------------------	-----------	--------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth _____ (a) Born alive and now living _____
Born alive but now dead _____ Stillborn 1

FULL NAME <u>FATHER</u> <u>Earl Johnson</u>	FULL MAIDEN NAME <u>MOTHER</u> <u>Thebing Liovel</u>
Residence (Usual place of abode) <u>Clementsville</u>	Residence (Usual place of abode) <u>Clementsville</u>
It non-resident, give place and State _____	It non-resident, give place and State _____
Color or race <u>W</u> Age at last Birthday <u>28</u> (Years)	Color or race <u>W</u> Age at last Birthday <u>20</u> (Years)
Birthplace <u>Wt Pleasant, Utah</u> (City and State or County)	Birthplace <u>Kambar</u> (City and State or County)
Occupation <u>Farmer</u>	Occupation <u>H on</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 4:30 P. M.
on the date above stated. Stillborn _____
(Signature) E. G. Harrison

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Driggs, Idaho
Filed 10-4-1930 Martha Marker
(Physician or midwife)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 8 1930
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72173

County of Teton
City of Clementsville
Registration District No. 77
Primary Registration District No. 2176

Local Registrar's No. 6

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn

504

(a) Residence. No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____
6. DATE OF BIRTH (month, day and year) 9-11-1930
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 11 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 9-11, 1930, to 9-11, 1930
that I last saw h. ✓ alive on ✓, 1930
and that death occurred, on the date stated above, at 4:30 p.m.
The CAUSE OF DEATH* was as follows:
Stillborn (Premature at 15-mo) Cause unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) _____
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? _____
Did an operation precede death? _____ Date of _____
Was there an autopsy? _____
What test confirmed diagnosis? _____
(Signed) W. H. Parkinson, M. D.
9-12, 1930 (Address) Bugge & Co.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

9. BIRTHPLACE (city or town) Clementsville
(State or country) Idaho
10. NAME OF FATHER Carl Johnson
11. BIRTHPLACE OF FATHER (city or town) Int Pleasant
(State or Country) Utah
12. MAIDEN NAME OF MOTHER Thelma Lloyd
13. BIRTHPLACE OF MOTHER (city or town) Kassab
(State or Country) _____

14. Informant Carl Johnson
(Address) Clementsville, Idaho
15. Filed 10-4-, 1930 Martha Marker
Registrar

19. Place of Burial, Cremation, or Removal Clementsville Id Date of Burial 9-12-1930
20. Undertaker _____ Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

RECEIVED NOV 6 1930
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 185275

County of ada

City of Boise

No. St. alphonsus St.

(If born in hospital or institution
give name.)

Registration District No. 2 State File No. 185275

Prim. Registration District No. 1004 Local Registrar's No. 520

FULL NAME OF CHILD Stella Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other?	and	Number in order of birth	Legiti- mate? <u>ye.</u>	Date of birth <u>Oct. 27</u> 19 <u>30</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead Stillborn 1

FULL NAME <u>Wayle Elmo Bresken</u>	FATHER	FULL MAIDEN NAME <u>Lilia Ada Hawes</u>	MOTHER
--	--------	---	--------

Residence (Usual place of abode) Quartzburg Id.

It non-resident, give place and State Same

Color or race W. Age at last Birthday 23 (Years)

Birthplace Boise Ida. (City and State or County)

Occupation miner

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 8:30 P.M.
on the date above stated.

(Signature) Alfred Budger M.D.

(Physician or midwife)

Address Boise Ida.

Filed 10-29-1930 W. H. Rhodes

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

... other evidence of life after birth.
neither breathes nor
is born

Address

(Physician or midwife)

Filed

19

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.
N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY.
Physician should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72232

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 278

2. FULL NAME Baby Breshears
(a) Residence. No. Quincyburg, Ida
(Usual place of abode.)
Length of residence in city or town where death occurred yrs. mo. ds. How long in U. S. if of foreign birth? yrs. mo. ds.

PERSONAL AND STATISTICAL PARTICULARS				
3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>		
5a. If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____				
6. DATE OF BIRTH (month, day and year) <u>October 27-1930</u>				
7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	<u>4</u>	<u>11</u>	<u>11</u>	<u>min.</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____				
9. BIRTHPLACE (city or town) <u>Boise, Ida</u> (State or country)				
PARENTS	10. NAME OF FATHER <u>V. E. Breshears</u>			
	11. BIRTHPLACE OF FATHER (city or town) <u>Idaho</u> (State or Country)			
	12. MAIDEN NAME OF MOTHER <u>Lilla Hauke</u>			
	13. BIRTHPLACE OF MOTHER (city or town) <u>Idaho</u> (State or Country)			
14. Informant (Address) <u>V. E. Breshears, Quincyburg, Ida</u>				
15. Filed <u>10 28 1930</u> <u>W. H. Rhodes</u> Registrar				

MEDICAL CERTIFICATE OF DEATH	
16. DATE OF DEATH	<u>Oct. 27</u> 19 <u>30</u> (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from <u>Oct 27</u> 19 <u>30</u> to <u>Oct 27</u> 19 <u>30</u> that I last saw him alive on <u>seal Oct 27</u> 19 <u>30</u> and that death occurred, on the date stated above, at _____ m. *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. The CAUSE OF DEATH* was as follows: <u>Ruptured aorta (probably one week prior to operation)</u> (duration) _____ yrs. _____ mos. _____ ds. CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds. 18. Where was disease contracted if not at place of death? _____ Did an operation precede death? <u>no</u> Date of _____ Was there an autopsy? <u>no</u> What test confirmed diagnosis? <u>Physical findings</u> (Signed) <u>Alfred Brady, M. D.</u> _____, 19 <u>30</u> (Address) _____ 19. Place of Burial, Cremation, or Removal <u>Moni Hill Cemetery</u> Date of Burial <u>Oct. 28</u> 19 <u>30</u> 20. Undertaker <u>Schreib & W. Carr</u> Address <u>Boise, Ida</u>	

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of** (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

NOV 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

185343

County of Bannock
City of Pocatello
No. St. Anthony St.
Hosp. _____

Registration District No. 28 State File No. _____

Prim. Registration District No. 216 Local Registrar's No. 18044

(If born in hospital or institution
give name.)

FULL NAME OF CHILD

Stillborn Logan

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child Female

Twin
Triplet
or other?

{ and } Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate? Yes

Date of
birth

10/9/30/

(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 7 (a) Born alive and now living 6

Born alive but now dead _____ Stillborn I

FATHER

FULL
NAME Ervin F. Logan

Residence (Usual place of abode) 58 Wilwood Ave.

If non-resident, give place and State _____

Color or race W Age at last Birthday 38

Birthplace Sedalia Mo. (Years)

(City and State or County)

Occupation Train Dispatcher

FULL

MAIDEN
NAME

MOTHER

Lillie Stewart

Residence (Usual place of abode) 58 Wilwood Ave

If non-resident, give place and State _____

Color or race W Age at last Birthday 34

Birthplace Cedar City Utah (Years)

(City and State or County)

Occupation H. W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 6:25 P. M.
on the date above stated.

(Signature) _____

(Physician or midwife)

Address _____

Filed _____

11/1 1934

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

There were no attending physician at birth, then the father, however, should make the return. A return is one that is not provided for and other persons are not.

I hereby certify that I attended the birth of the child, who was born on the date above stated.

INTESTATE OR ATTORNEY OF PHYSICIAN OR MIDWIFE

Signature of Physician or Midwife

Color of face

Weight at birth

Place of birth

Month and day of birth

Year of birth

Sex of child

Age of child

Place of residence

Signature of parent

Signature of physician or midwife

Signature of parent

Signature of physician or midwife

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE DISTRICT OF COLUMBIA, IN THE CITY OF WASHINGTON, D. C.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
Physician should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. St. Anthony's Hospital)

DO NOT WRITE IN THIS SPACE

State File No. 72259Local Registrar's No. 5921

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Beverly Logan(a) Residence. No. Pocatello, Idaho. St.

(Usual place of abode.)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) October 9, 1930

7. AGE Years Months Days Still less than 1 day.
0 0 0 Born hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello, Idaho.
(State or country)

10. NAME OF FATHER

Ervine F. Logan11. BIRTHPLACE OF FATHER (city or town)
(State or Country)Missouri12. MAIDEN NAME OF MOTHER Lillie Stewart13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)Cedar City, Utah.14. Informant Ervine F. Logan
(Address) 58 Willowood Ave. Pocatello, Ida.15. Filed 10/11/30. 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 9, 1930. 19.....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Still Born Oct 9, 1930

that I last saw him alive on..... 19.....

and that death occurred, on the date stated above, at..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Probable Birth Injuries
head in transverse position
in bony Pelvis. Forcep delivery

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) O. Hall, M. D.
10/10/30. 19..... (Address) Pocatello, Ida.

19. Place of Burial, Cremation, or Removal
Mountain View Cemetery
Pocatello, Idaho.

Date of Burial

10/11/30. 19.....

20. Undertaker

Arthur W. Hall

Address

Pocatello

204

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Saleman, (b) Grocery;** (a) **Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.,** of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia, "PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH PRECEDENT NOV 5 1930 STATE OF IDAHO
County of Blaine DEPARTMENT OF PUBLIC WELFARE
City of Paris BUREAU OF VITAL STATISTICS
No. St. CERTIFICATE OF BIRTH
356-115004-214 Registration District No. 53 State File No. 185374
(If born in hospital or institution give name.) Prim. Registration District No. Local Registrar's No. 535

FULL NAME OF CHILD
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate mate <u>Yes</u>	Date of birth <u>Oct 15</u> 19 <u>30</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------	-------------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 4 (a) Born alive and now living 3
Born alive but now dead Stillborn 1

FATHER		MOTHER	
FULL NAME <u>F. Ralph Lewis</u>	FULL MAIDEN NAME <u>Martha Kaufmann</u>		
Residence (Usual place of abode) <u>Paris</u>	Residence (Usual place of abode) <u>Paris</u>		
If nonresident, give place and State	If nonresident, give place and State		
Color or race <u>White</u> Age at last Birthday <u>36</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>33</u> (Years)		
Birthplace <u>Idaho</u> (City and State or Country)	Birthplace <u>Switzerland</u> (City and State or Country)		
Occupation <u>Merchant</u>	Occupation <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*
Mother has spinal deformity.
I hereby certify that I attended the birth of this child, who was born alive at 8:40 a. M.
on the date above stated. Stillborn

(Signature) O. O. Moore M.D.
Paris Idaho
(Physician or midwife)
*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address
Filed Oct 16 1930 Mrs. J. B. Skinner
Per Mrs. Arthur Hess.
Registrar.

MD

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH **Bingham**
County of
City of **Blackfoot**
No. **N. Oak St.** St.

168 122-006-813
(If born in hospital or institution
give name.)

FULL NAME OF CHILD **Alton Johnson**

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male	Twin Triplet or other? { and } Number in order of birth	Legitimate? yes	Date of birth Oct. 22, 1930 (Month) (Day) (Year)
--------------------------	--	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? **Neo-Silvol 10%**

Number of child of this mother, including present birth **2** (a) Born alive and now living **1**
Born alive but now dead **1** Stillborn **1**

FATHER
FULL NAME **Lional Johnson**

Residence (Usual place of abode) **Blackfoot**

If non-resident, give place and State **White**

Color or race **white** Age at last Birthday **27**

Birthplace **Oklahoma** (Years)

Occupation **Section Hand** (City and State or County)

MOTHER
FULL MAIDEN NAME **Mary Hatch**

Residence (Usual place of abode) **Blackfoot**

If non-resident, give place and State **white**

Color or race **white** Age at last Birthday **24**

Birthplace **High Idaho** (Years)

Occupation **Housewife** (City and State or County)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was **Stillborn** at **12:45 P. M.**
on the date above stated.

(Signature) **J. D. Hampton M.D.**

(Physician or midwife)

Address **Blackfoot, Idaho**

Filed **Nov 7 1930** **M. H. Talbot** Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 11-19-2001 BY 60322 UCBAW/STP

There were no attending physician
or midwife from the latter, inasmuch as
the child was born in a hospital
and the mother provided not
showing any evidence of the latter birth

I hereby certify that I attended the birth of this child, who was [redacted] at [redacted]

(Signature)

Filed
Address

(Physician or Midwife)

STATEMENT OF ATTENDING PHYSICIAN OR MIDWIFE

Registration
(City and State of County)
Birthplace
(Color or race)
If non-resident, residence and date
Residence (City and State of County)
Name
MAYOR
MAYOR
MAYOR

Number of child or child or children, including present birth
What hospital or place was used in present birth
Name of attending physician or midwife
Name of mother
Name of father
(If child born, date of birth)
(If child born, date of birth)
(If child born, date of birth)

Registration Number
State of [redacted]
Registration Number [redacted]

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
STATE OF [redacted]
[redacted]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72299

PLACE OF DEATH

County of Bingham
City of Blackfoot
Idaho

Registration District No. 121Primary Registration District No. 2144Local Registrar's No. 154

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alton J. Johnson(a) Residence, No. 13 & N. 4th St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. Single, Married, Widowed, or Divorced (write the word)

✓

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of✓

6. DATE OF BIRTH (month, day and year)

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or
min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

✓

(b) General nature of industry, business, or establishment in which employed (or employer)

✓

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

Blackfoot Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

Blackfoot Idaho

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

Mary Stahly
Idaho

14. Informant

(Address)

15. Filed

Geo. Lionel Johnson
Blackfoot Idaho
Oct 22 1930
Mrs. Stahly
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

10 - 22

(Month)

(Day)

1930
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 221930, to

19

that I last saw him alive on

19

and that death occurred, on the date stated above, at

m.

The CAUSE OF DEATH* was as follows:

still born due to heavy lifting about 5 hrs. premature
(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ✓ Date of ✓Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

10 - 22 1930 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Methodist Cemetery Oct 23 1930

20. Undertaker

Address

Methodist Cemetery Blackfoot Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of

City of

No.

St.

(If born in hospital or institution
give name.)

FULL NAME OF CHILD

Registration District No.

State File No.

Prim. Registration District No.

Local Registrär's No.

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	male	Twin Triplet or other?	{ and }	Number in order of birth	Legiti- mate?	yes	Date of birth	Oct 11	19 30
							(Month)	(Day)	(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth.

(a) Born alive and now living.

Born alive but now dead.

Stillborn.

FATHER
FULL NAME

Residence (Usual place of abode)

If non-resident, give place and State

Color or race

Age at last Birthday

Birthplace
(City and State or County)

Occupation

MOTHER
FULL
MAIDEN
NAME

Residence (Usual place of abode)

If non-resident, give place and State

Color or race

Age at last Birthday

Birthplace
(City and State of County)

Occupation

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.

(Signature)

Physician or midwife

Address

Filed

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

2. If in case of stillborn child, the mother has not yet had a physician or midwife, then the father, household, or neighbors should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

{Where there was no attending physician or midwife, then the father, household, or neighbors should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

(Physician or midwife)

Address

Filed

Registration

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

{ Born alive
 { Stillborn

I hereby certify that I attended the birth of this child, who was

on the date above stated.

Occupation

(City and State or County)

(City and State or County)

(Years)

Age at last Birthday (Years)

(Years)

Residence (Last place of abode)

NAME

FATHER

MOTHER

NAME

Born alive for now dead

Number of child of this mother, including present birth

What prophylactic was used to prevent Ophthalmia Neonatorum?

(To be answered only in case of plural births)

Child

or other

and in order

Number

Legiti-

mately

Date of

(Month)

(Day)

19

(Year)

FULL NAME OF CHILD

(If born in hospital or institution give name)

No. St.

City of

County of

PLACE OF BIRTH

BUREAU OF VITAL STATISTICS
 DEPARTMENT OF PUBLIC WELFARE
 STATE OF IDAHO

CERTIFICATE OF BIRTH

Prim. Registration District No. Local Registrar's No.
 Registration District No. State File No.

STATE OF IDAHO

RECEIVED NOV 10 1930

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 72303

PLACE OF DEATH

County of BinghamCity of ShelbyRegistration District No. 21Primary Registration District No. 21

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Thornton

(a) Residence. No. St.

(Usual place of abode.)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds. (If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W. Single Married Widowed Divorced (write the word.) Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Widowed6. DATE OF BIRTH (month, day and year) Still born7. AGE Years Months Days ☒ LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. ✓(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9. BIRTHPLACE (city or town) Woodville Ida
(State or country)10. NAME OF FATHER C. J. Thornton11. BIRTHPLACE OF FATHER (city or town) American Fork Utah
(State or Country)12. MAIDEN NAME OF MOTHER Mary J. Russell13. BIRTHPLACE OF MOTHER (city or town) Goodberry Utah
(State or Country)14. Informant (Address) C. J. Thornton
Shelby Idaho15. Filed Oct 12 30 Mo. Helen E. Patric
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 11 28
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

Still born
that I last saw him alive on 19.....

and that death occurred, on the date stated above, at m.

State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. The CAUSE OF DEATH was as follows:

Recorded about one week before birth
Caused by a detached PlacentaCONTRIBUTORY (Secondary) Placenta
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. J. Thornton M. D.
Oct 11 30 (Address) Shelby Ida19. Place of Burial, Cremation, or Removal Iona, Idaho Date of Burial Oct 12 - 193020. Undertaker None Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

PHYSICIAN

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Saleman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile Factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home**, who are engaged in the duties of the household only (not paid **House-keepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At Home**, and children not gainfully employed, as **At school or At Home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia**; **Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.**, **Carcinoma, Sarcoma, etc.**, of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping Cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED NOV 10 1930 STATE OF IDAHO
County of Bingham DEPARTMENT OF PUBLIC WELFARE
City of Blackfoot BUREAU OF VITAL STATISTICS

No. R 7 D 3 St.

CERTIFICATE OF BIRTH

S
185431

Registration District No. 121 State File No. 3194
(If born in hospital or institution give name.) Prim. Registration District No. 328 Local Registrar's No. 328

FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u> }	Legitimate? <u>yes</u>	Date of birth <u>Oct 7</u> 19 <u>30</u> (Month) (Day) (Year)
----------------------------	----------------------------------	--	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead Stillborn 1

FATHER FULL NAME <u>Torval Alfred Buttcane</u>	FULL MAIDEN NAME <u>Ina Whitmill</u>
---	--------------------------------------

Residence (Usual place of abode) <u>Blackfoot-R 7 D 3</u>	Residence (Usual place of abode) <u>Blackfoot-R #3</u>
---	--

If non-resident, give place and State <u> </u>	If non-resident, give place and State <u> </u>
---	---

Color or race <u>White</u> Age at last Birthday <u>22</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>20</u> (Years)
---	---

Birthplace <u>Blackfoot</u> (City and State or County)	Birthplace <u>Ida</u> (City and State or County)
--	--

Occupation <u>Salesman</u>	Occupation <u>Housewife</u>
----------------------------	-----------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 3:00 p.m. on the date above stated.

(Signature) W W Beck

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Blackfoot Ida

Filed Nov 5 1930 Wm Hubert E. Tator
Registrar.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 12-13-2000 BY 60322 UCBAW/STP

There is no other evidence of the child's birth
child is one first mother's possession not
etc. should make this return. A physician
or midwife from the father's possession
exists there was no attending physician

185131

STATE OF OHIO
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. 1 State The No. 1

Full Registration District No. 1 Local Registration No. 1

The child's name at birth was "Elizabeth" for name of child

Sex of child (M or F) F

Color of child (Caucasian, Negro, etc.) Caucasian

Weight of child at birth (in pounds) 10

Length of child at birth (in inches) 20

Head circumference at birth (in inches) 14

Birth date (Month, Day, Year) 1900 12 15

Place of birth (City and State of Country) Cincinnati Ohio

Residence (Last place of abode) Cincinnati Ohio

Place of birth (Give place and date) Cincinnati Ohio

Color of child (Caucasian, Negro, etc.) Caucasian

Birthplace (City and State of Country) Cincinnati Ohio

Occupation (If any) None

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of the child, who was Elizabeth M.

(Signature)

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72285

PLACE OF DEATH

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194

Local Registrar's No. 146

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn Buttane

(a) Residence. No. St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 7, 1930

7. AGE Stillborn Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Blackfoot, Idaho
(State or country)

PARENTS

10. NAME OF FATHER Jorval Alfred Buttane

11. BIRTHPLACE OF FATHER (city or town) Blackfoot
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER Ina Whitmill

18. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant Jorval Buttane
(Address) Blackfoot

15. Filed Oct. 8, 1930 Mr. Halen E. Catrie
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 7, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7, 1930, to Oct 7, 1930
that I last saw him alive on Stillborn, 19...
and that death occurred, on the date stated above, at... m.
The CAUSE OF DEATH* was as follows:

Occiput Posterior
Instrument Delivery
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. W. Beck M. D.
10/8, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shore City Cemetery Date of Burial Oct. 8, 1930

20. Undertaker E. T. Beck Address Blackfoot

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE REBIRTH

NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bingham
City of Thermas
No. _____ St. _____

CERTIFICATE OF BIRTH 185435

(If born in hospital or institution
give name.)

Registration District No. 121 State File No. _____
Prim. Registration District No. 2194 Local Registrar's No. 324

FULL NAME OF CHILD Steelbush
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u>1</u> and <u>1</u>	Number in order of birth <u>1</u>	Legiti- mate? <u>yes</u>	Date of birth <u>Oct 3</u> 19 <u>30</u> (Month) (Day) (Year)
--------------------------	--	---	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth. 10 (a) Born alive and now living 7
Born alive but now dead _____ Stillborn 3

FATHER		MOTHER	
FULL NAME <u>Wm J. Van Orden</u>	FULL MAIDEN NAME <u>Hazel May Baker</u>		
Residence (Usual place of abode) <u>Thermas</u>	Residence (Usual place of abode) <u>Thermas</u>		
If non-resident, give place and State _____	If non-resident, give place and State _____		
Color or race <u>White</u> Age at last Birthday <u>43</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>37</u> (Years)		
Birthplace <u>Utah</u> (City and State or County)	Birthplace <u>Utah</u> (City and State or County)		
Occupation <u>Farmer</u>	Occupation <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 8:45 p. M. on the date above stated.

(Signature) W W Beck

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Blackfoot, Ida.
Filed Nov 5 1930 Mr. Walter D. Doherty
Registrar.

RECEIVED BY THE BUREAU OF THE INSPECTION OF THE DEPARTMENT OF THE INTERIOR
 OFFICE OF THE SECRETARY OF THE INTERIOR
 WASHINGTON, D. C.
 MAY 10 1908

It is hereby certified that I attended the birth of this child, who was born on the 10th day of May, 1908, at the residence of the mother, at the address of _____, in the County of _____, State of _____.

I hereby certify that I attended the birth of this child, who was born on the 10th day of May, 1908, at the residence of the mother, at the address of _____, in the County of _____, State of _____.

STATE OF _____

County of _____

City and State of _____

Age at last birth _____

Color of hair _____

Color of eyes _____

Color of skin _____

Color of hair _____

Color of hair _____

Color of hair _____

Color of hair _____

Color of hair _____

Color of hair _____

Color of hair _____

Color of hair _____

Color of hair _____

Color of hair _____

Color of hair _____

Color of hair _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72292

PLACE OF DEATH

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194

Local Registrar's No. 141

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn Van Orden

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6. DATE OF BIRTH (month, day and year) Oct. 3, 1930

7. AGE Stillborn
Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Blackfoot, Ida
(State or country)10. NAME OF FATHER William J. Van Orden11. BIRTHPLACE OF FATHER (city or town) Utah
(State or Country)12. MAIDEN NAME OF MOTHER Lazel May Baker13. BIRTHPLACE OF MOTHER (city or town) Utah
(State or Country)14. Informant Wm J Van Orden
(Address) Blackfoot, Ida15. Filed Oct 6 1930 Wm J Van Orden
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 3 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 3, 1930, to Oct 3, 1930that I last saw him alive on Stillborn

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Prolapsed Cord

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? No Date of _____Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W W Beck M. D.
Oct 4, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Traverse-Thomson Date of Burial 10/4/30

20. Undertaker Modern Mortuary Address Blackfoot

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital" "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED NOV 7 1930
County of Banner
City of Sandpoint, Ida.
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Parnell Registration District No. 76 State File No. 185456
(If born in hospital or institution
give name.) Prim. Registration District No. 2155 Local Registrar's No. 142
FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other?	{ and }	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Oct. 14</u> 19 <u>30</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What prophylactic was used to prevent Ophthalmia Neonatorum? Silver Nitrate
Number of child of this mother, including present birth 1st (a) Born alive and now living _____
Born alive but now dead _____ Stillborn 1

FATHER		MOTHER	
FULL NAME <u>Oliver A. Petersen</u>	FULL MAIDEN NAME <u>Rachel Caroline Jacobson</u>		
Residence (Usual place of abode) <u>Sandpoint, Ida.</u>	Residence (Usual place of abode) <u>Sandpoint, Ida.</u>		
If non-resident, give place and State _____	If non-resident, give place and State _____		
Color or race <u>White</u> Age at last Birthday <u>35</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>20</u> (Years)		
Birthplace <u>Jackson Co. Wisconsin</u> (City and State or County)	Birthplace <u>Eclair, Wisconsin</u> (City and State or County)		
Occupation <u>Teacher</u>	Occupation <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 9 P. M.
on the date above stated.
(Signature) Floyd G. Hegde

(Physician or midwife)

Address Sandpoint, Idaho
Filed Nov 4 1930 U.S. Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF ILLINOIS
 DEPARTMENT OF PUBLIC HEALTH
 DIVISION OF VITAL STATISTICS

Registration District No. _____
 Local Registration District No. _____

(If deceased, substitute the word "DECEASED" for name of child)

Place of birth _____
 Date of birth _____
 Sex _____
 Race _____
 Color _____
 Age at last birthday _____
 Birthplace _____
 Occupation _____

Number of child in this family, including person, birth _____

Both alive and now living _____
 Both alive but now dead _____
 Both dead _____

Signature of child _____
 Signature of parent _____
 Signature of physician _____

Color of hair _____
 Color of eyes _____
 Birthplace _____
 Occupation _____

Signature of child _____
 Signature of parent _____
 Signature of physician _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
 on the _____ day of _____, 19____.

(Signature)
 (Physician or Midwife)

Signature of parent _____
 Signature of physician _____
 Signature of midwife _____

RECEIVED NOV 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 72315

PLACE OF DEATH

County of BonnerCity of SandpointRegistration District No. 78Primary Registration District No. 2155(No. Parnell Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 762. FULL NAME Infant Peterson(a) Residence. No. Sandpoint RFD #1 St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 14, 19307. AGE Years Months Days If LESS than 1 day, hrs. or min. Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Sandpoint Ida
(State or country)10. NAME OF FATHER Oliver Peterson11. BIRTHPLACE OF FATHER (city or town) Wise
(State or Country)12. MAIDEN NAME OF MOTHER Rachel Jacobson13. BIRTHPLACE OF MOTHER (city or town) Wise
(State or Country)14. Informant Oliver Peterson
(Address) Sandpoint RFD #115. Filed Oct 15, 1930 Violet Allen
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Stillborn, 19

that I last saw him alive on _____, 19

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Difficult delivery
9 months gestation

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Mal position
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) Floyd G Wendle, M. D.
Oct 15, 1930 (Address) Sandpoint, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lakemore Cemetery Date of Burial 10/15 193020. Undertaker Funeral Co Address Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE ~~STAMP~~

NOV 10 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 185513

County Anyon
City of Nampa
No. R. 2 St.

Registration District No. 7 State File No. _____

(If born in hospital or institution give name.)
Prim. Registration District No. 7006 Local Registrar's No. 22

FULL NAME OF CHILD Stillbirth Waldvogel
(If stillborn, substitute the word "stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate <u>Yes</u>	Date of birth <u>10-3-1930</u> (Month) (Day) (Year)
--------------------------	------------------------------	-----------	--------------------------------	-----------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol 1.0%

Number of child of this mother, including present birth. 3 (a) Born alive and now living. 3

Born alive but now dead one Stillborn one

FATHER FULL NAME <u>Clarence Franklin Waldvogel</u>	MOTHER FULL MAIDEN NAME <u>Leatha Bea Newland</u>
--	--

Residence (Usual place of abode) R. 2 Nampa

If non-resident, give place and State _____

Color or race W. Age at last Birthday 29 (Years)

Birthplace Warrensburg Mo. (City and State or County)

Occupation Farmer

If non-resident, give place and State _____

Color or race W. Age at last Birthday 26 (Years)

Birthplace Anyon Kan. (City and State or County)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 9:30 A. M. on the date above stated.

(Signature) J. E. Horton
M. W.
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Nampa Idaho

Filed 11-8-30 Leatha Canaway Registrar.

1947

STATE OF NEW YORK
IN SENATE
January 14, 1947

REPORT OF THE
COMMISSIONER OF THE DEPARTMENT OF SOCIAL SERVICES
ON THE
PROCEEDINGS OF THE BOARD OF SOCIAL SERVICES
IN THE MATTER OF THE
APPEAL OF THE
STATE OF NEW YORK

ALBANY, NEW YORK
JANUARY 14, 1947
PRINTED BY THE
STATE OF NEW YORK
JANUARY 14, 1947

ALBANY, NEW YORK
JANUARY 14, 1947
PRINTED BY THE
STATE OF NEW YORK
JANUARY 14, 1947

ALBANY, NEW YORK
JANUARY 14, 1947
PRINTED BY THE
STATE OF NEW YORK
JANUARY 14, 1947

ALBANY, NEW YORK
JANUARY 14, 1947
PRINTED BY THE
STATE OF NEW YORK
JANUARY 14, 1947

ALBANY, NEW YORK
JANUARY 14, 1947
PRINTED BY THE
STATE OF NEW YORK
JANUARY 14, 1947

ALBANY, NEW YORK
JANUARY 14, 1947
PRINTED BY THE
STATE OF NEW YORK
JANUARY 14, 1947

ALBANY, NEW YORK
JANUARY 14, 1947
PRINTED BY THE
STATE OF NEW YORK
JANUARY 14, 1947

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

DEC 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72697

PLACE OF DEATH

County of Canyon

City ofampa R. 2

Registration District No. 7

Primary Registration District No. 2006

Local Registrar's No. 136

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. Stillborn M. Waldvogel

(Usual place of abode)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. Single, Married, Widowed, or Divorced, (write the word)

Single

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years

Months

Days

If LESS than 1 day,
hrs. or
min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14.

Informant

(Address)

15.

Filed

10-4

1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct.

3

1930

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

on 10-3, 1930, to 10-3, 1930

that I last saw him alive on 10-3, 1930

and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? 20 Date of 10-3

Was there an autopsy? 15

What test confirmed diagnosis?

(Signed)

10-4, 1930 (Address)ampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

ampa R. 2

10-3 1930

20. Undertaker

Address

C. F. Waldvogel

ampa R. 2

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH OCT 31 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 185559

County of Cassia
City of Burley
No. _____ St. _____

Registration District No. _____ State File No. _____

(If born in hospital or institution
give name.)

Prim. Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD

Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Sept 3</u> 19 <u>30</u> (Month) (Day) (Year)
--------------------------	---	-------	--------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? no shock 570

Number of child of this mother, including present birth. (a) Born alive and now living 1

Born alive but now dead. _____ Stillborn 1

FATHER
FULL NAME M. M. Corner
Residence (Usual place of abode) Burley Idaho
If non-resident, give place and State _____
Color or race White Age at last Birthday 25 (Years)
Birthplace La Grande Oregon
(City and State or County)
Occupation Mechanic Park Pump

MOTHER
FULL MAIDEN NAME Bessie Holst
Residence (Usual place of abode) Burley Ida
If non-resident, give place and State _____
Color or race White Age at last Birthday 27 (Years)
Birthplace Brigham City Utah
(City and State or County)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 10:30 A.M.
on the date above stated.

Premature (Signature) H. H. Cooper M.D.
Physician and Surgeon
(Physician or midwife)

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Address Burley Idaho

Filed 10-10 1930 F. Hutter
Registrar

DEPARTMENT OF JUSTICE
BUREAU OF PRISON
WASHINGTON, D. C.

Registration District No. _____
Prison in which confined _____

STATE OF _____

(1) Name of prisoner _____

Age _____ Sex _____
Color _____ Height _____ Weight _____
Build _____ Eyes _____ Hair _____
Tattoos _____ Scars _____

(2) Name of person to whom committed _____

Address _____
City _____ State _____
Occupation _____

Reason for commitment _____

Date of commitment _____

Signature of committing officer _____

Signature of receiving officer _____

Signature of prisoner _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
Physician should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

PHYSICIAN

RECEIVED OCT 31 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72375

PLACE OF DEATH

County of Cassia

City of Burley

Registration District No.

Primary Registration District No.

(No.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Conner

(a) Residence. No. St.

(Usual place of abode.)

Length of residence in city or town where death occurred yrs. mo. ds. How long in U. S. if of foreign birth? yrs. mo. ds. (If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. Single, Married, Widowed, or Divorced (write the word.) Single
-----------------------	----------------------------------	--

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) **Sept. 3 1930**

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				Still Born

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work.(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) **Burley**
(State or country) **Idaho.**

10. NAME OF FATHER

Charles M Conner11. BIRTHPLACE OF FATHER (city or town) **La Grande**
(State or Country) **Oregon**12. MAIDEN NAME OF MOTHER **Bessie Holst**13. BIRTHPLACE OF MOTHER (city or town) **Brigham City**
(State or County) **Utah.**14. Informant **C.M. Conner**(Address) **Burley Ida**15. Filed **10-15-30**, 1930

Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 3 1930

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred, on the date stated above, at **11:30 a.m.**

State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. The CAUSE OF DEATH was as follows:

— Dead born —

(duration) yrs. mos. ds.

CONTRIBUTORY **Immature birth**
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) **G. H. Cooper** M. D.**Sept. 19, 1930** (Address) **Burley, Ida.**

19. Place of Burial, Cremation, or Removal

Burley Ida

Date of Burial

Sept. 4 193020. Undertaker **D.E. Johnson**Address **Burley**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid House-keepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of** (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia, "PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED NOV 12 1930
County of Idaho
City of Minona
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

185671

Registration District No. 105 State File No. _____
(If born in hospital or institution give name.) Prim. Registration District No. 2183 Local Registrar's No. 55
FULL NAME OF CHILD Yvonne Marie Orr (Stillbirth)
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>F</u>	Twin Triplet or other? _____	and	Number in order of birth _____	Legiti- mate? <u>yes</u>	Date of birth <u>Oct 25 1930</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead _____ Stillborn _____

FATHER	MOTHER
FULL NAME <u>Harvey Orr</u>	FULL MAIDEN NAME <u>Viola Josephine Johnson</u>
Residence (Usual place of abode) <u>Minona, Idaho</u>	Residence (Usual place of abode) <u>Minona, Ida</u>
If non-resident, give place and State _____	If non-resident, give place and State _____
Color or race <u>W.</u> Age at last Birthday <u>28</u> (Years)	Color or race <u>W.</u> Age at last Birthday <u>23</u> (Years)
Birthplace <u>S. Dakota</u> (City and State or County)	Birthplace <u>Green Creek Ida</u> (City and State or County)
Occupation <u>Farming</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 6 A. M.
on the date above stated.

(Signature) Nesley F. Orr M.D.

(Physician or midwife)

Address Cottonwood, Idaho

Filed 10/31 1930 N. F. Orr Jr. D.C.
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

W. J. ...
...
...
...
...
...

1. The first of these is the fact that the
the only one who has been able to do so.

STATION TO KAJORYHI DELIVERED TO 10-10-1950

(SECRET)

CONFIDENTIAL

CONFIDENTIAL

[illegible][illegible]

1000000
1000000
1000000

CONFIDENTIAL

[illegible]

FORM V. S. No. 5-25 M. 1-19.

REC'D

NOV 12 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho
City of MinonaRegistration District No. 105Primary Registration District No. 2183

(No. St.)

File No. 72423Registered No. 97

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Yvonne Marie Orr (Stillborn)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

A

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

October 25 1930
(Month) (Day) (Year)

7. AGE

✓ Yrs. ✓ Mos. ✓ ds.IF LESS than 1 day
how many ✓ hrs.
or ✓ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ✓(b) General nature of industry, business or establishment in which employed (or employer) ✓

9. BIRTHPLACE

(State or Country) Minona, Idaho

10. NAME OF FATHER

Harvey Orr

11. BIRTHPLACE OF FATHER

(State or Country) Dakota

12. MAIDEN NAME OF MOTHER

Viola Johnson

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harvey Orr(Address) Minona, Ida

15.

Filed 10/25 1930 H. F. Orr 9B
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

26
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19..... to 19.....

that I last saw h..... alive on 19.....

and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Stillbirth due to version in shoulder presentation. 12 lb. baby.

..... (Duration) Yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Harvey F. Orr

M. D.

10/25/30(Address) Cottonwood Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Minona Ida.10-25-1930

20. UNDERTAKER

ADDRESS

Harvey OrrMinona

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH LD NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

185719

County of Kootenai
City of Coeur d'Alene
No. 807-C St. 415 706 020-386

Registration District No. 1050 State File No. 185719

(If born in hospital or institution
give name.)

Prim. Registration District No. 30 Local Registrar's No. 163

FULL NAME OF CHILD

Stillbirth Davis (Five months)
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>4</u>	Legitimate? <u>Yes</u>	Date of birth <u>Sept. 6</u> 19 <u>30</u> (Month) (Day) (Year)
--------------------------	-----------------------------------	-----------------------------------	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? ✓

Number of child of this mother, including present birth 4 (a) Born alive and now living 3
Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME <u>Wm. L. Davis</u>	FULL MAIDEN NAME <u>Irma Stanley</u>
Residence (Usual place of abode) <u>CDA</u>	Residence (Usual place of abode) <u>CDA</u>
If non-resident, give place and State	If non-resident, give place and State
Color or race <u>W</u> Age at last Birthday <u>49</u> (Years)	Color or race <u>W</u> Age at last Birthday <u>35</u> (Years)
Birthplace <u>Sumner, Iowa</u> (City and State or County)	Birthplace <u>Mountain Home, Idaho</u> (City and State or County)
Occupation <u>laborer</u>	Occupation <u>housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 9:30 A. M.
on the date above stated.

(Signature) Harold T. Anderson
(Physician or midwife)

Address Coeur d'Alene, Ida.
Filed 9/29 1930 H. J. Sturges
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

UNITED STATES OF AMERICA
DEPARTMENT OF JUSTICE
BUREAU OF PRISON INVESTIGATION
WASHINGTON, D. C.

Registration Number No. _____
Prison Number and District No. _____

NAME OF CHILD

Age of child _____
Sex _____
Date of birth _____
Place of birth _____
(If born in United States, give State and County)

What prophylactic was used to prevent diphtheria?

Number of child at time isolated, including present birth _____
(a) Born alive and now living _____

NAME _____
MOTHER _____
FATHER _____
Address _____
City and State _____

Occupation _____
City and State of birth _____
Date of birth _____
If non-resident give place and date _____
Residence (last known address) _____
Cause of death _____
Date of death _____
Place of death _____
Occupation _____
City and State of birth _____
Date of birth _____
If non-resident give place and date _____
Residence (last known address) _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born at _____
on the _____ day of _____, 19____.

(Signature)

There was no attending physician or midwife then the father, household, or family attended the birth. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address _____

Filed _____

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH Idaho OCT 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Lemhi
City of Baker
No. _____ St. _____

CERTIFICATE OF BIRTH

Registration District No. 41 State File No. 185738

(If born in hospital or institution
give name.)

Prim. Registration District No. 2116 Local Registrar's No. _____

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>ye</u>	Date of birth <u>Aug 12 1930</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth two (a) Born alive and now living one

Born alive but now dead _____ Stillborn one

FATHER
FULL NAME James A. Owens

Residence (Usual place of abode) Baker

If nonresident, give place and State _____

Color or race wh Age at last Birthday 24 (Years)

Birthplace Ida (City and State or Country)

Occupation laborer

MOTHER
FULL MAIDEN NAME Ruth Fry

Residence (Usual place of abode) Baker

If nonresident, give place and State _____

Color or race wh Age at last Birthday 23 (Years)

Birthplace Baker Ida (City and State or Country)

Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 12 M.
on the date above stated.

(Signature) F. S. Wright

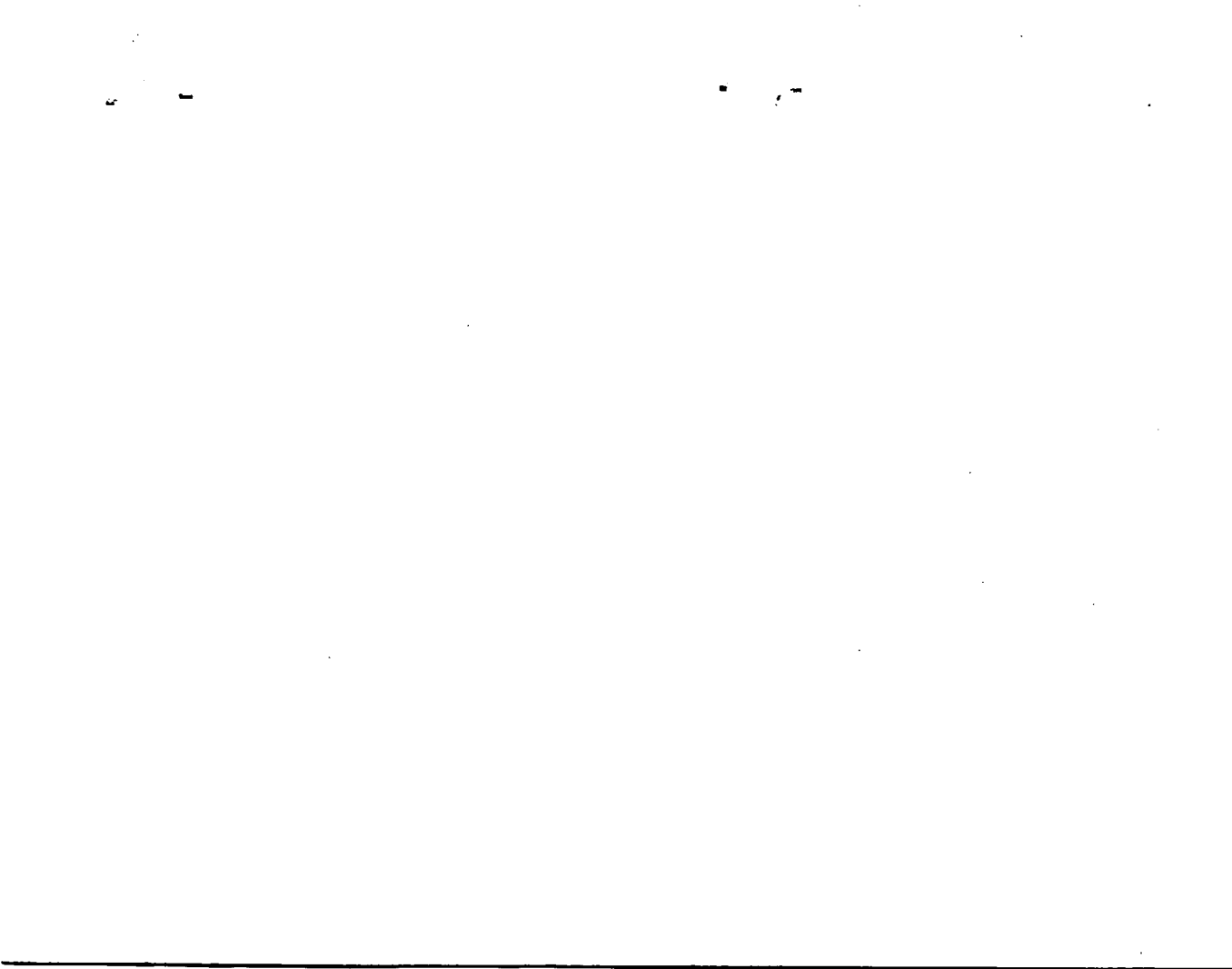
(Physician or midwife)

Address Idaho

Filed #101 1930 Chas. Bellamy

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED SEP 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 11775

- PLACE OF DEATH

County of LatahCity of BakerRegistration District No. 11Primary Registration District No. 2116Local Registrar's No. 206(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Hillbirth

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. Single, Married, Widowed,
or Divorced (write the word)5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years

Months

Days

If LESS than 1 day,
_____ hrs. or
_____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14.

Informant

(Address)

15.

Filed

9/10, 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 11th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1, 1930, to Aug 11, 1930

that I last saw him alive on _____, 19____

and that death occurred on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date of _____Was there an autopsy? noWhat test confirmed diagnosis? PS Wright(Signed) Aug 10, 1930, M. D.(Address) Salmon*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Salmon Cemetery 8/12/ 1930

20. Undertaker

Address

McNeely Salmon Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO		S	
County of <u>Lawrence</u>		DEPARTMENT OF PUBLIC WELFARE			
City of <u>Winchester</u>		BUREAU OF VITAL STATISTICS			
No. St.		CERTIFICATE OF BIRTH		185749	
<u>Winchester Hospital</u>		Registration District No. <u>60</u>	State File No.		
(If born in hospital or institution give name.)		Prim. Registration District No. <u>217</u>	Local Registrar's No. <u>36</u>		
FULL NAME OF CHILD <u>Stillbirth</u>		(If stillborn, substitute the word "Stillbirth" for name of child)			
Sex of Child <u>Female</u>	Twin Triplet or other? <input type="checkbox"/>	and <input type="checkbox"/>	Number in order of birth <u>23</u>	Legitimate? <u>Yes</u>	Date of birth <u>Oct. 25</u> 19 <u>30</u> (Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? <u>None</u>					
Number of child of this mother, including present birth. <u>None</u> (a) Born alive and now living <u>None</u>					
Born alive but now dead <u>None</u> Stillborn <u>One</u>					
FATHER		MOTHER			
FULL NAME <u>Chas W. Hunter</u>		FULL MAIDEN NAME <u>Miss Laura Prentiss</u>			
Residence (Usual place of abode) <u>Winchester, Idaho</u>		Residence (Usual place of abode) <u>Winchester, Ida</u>			
If non-resident, give place and State.		If non-resident, give place and State.			
Color or race <u>White</u> Age at last Birthday <u>23</u> (Years)		Color or race <u>White</u> Age at last Birthday <u>21</u> (Years)			
Birthplace <u>Spartanburg, W. Va.</u> (City and State or County)		Birthplace <u>Asotin, Wash.</u> (City and State or County)			
Occupation <u>Miner</u>		Occupation <u>Housewife</u>			

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 8:30 A.M. on the date above stated.

(Signature) A. B. Hollister, M.D.

(Physician or midwife)

Address Winchester, Idaho

Filed 11/4 1930 R. B. Dwyer

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

DEPARTMENT OF JUSTICE
 DIVISION OF INVESTIGATION
 UNITED STATES OF AMERICA

PLATE NO. 1

Date of Birth _____
 Sex _____
 Place of Birth _____
 Date of Admission _____
 Name of Institution _____

LET STATE OF CHARGE

Charge _____
 Section _____
 Chapter _____
 Article _____

That I, the undersigned, who used to present Criminal in _____

Charge of _____ of the mother, who was present _____
 and alive and not dead _____

Charge _____
 Section _____
 Chapter _____
 Article _____

Charge _____
 Section _____
 Chapter _____
 Article _____

Charge _____
 Section _____
 Chapter _____
 Article _____

Charge _____
 Section _____
 Chapter _____
 Article _____

Charge _____
 Section _____
 Chapter _____
 Article _____

Charge _____
 Section _____
 Chapter _____
 Article _____

Charge _____
 Section _____
 Chapter _____
 Article _____

Charge _____
 Section _____
 Chapter _____
 Article _____

DEPARTMENT OF JUSTICE
 DIVISION OF INVESTIGATION
 UNITED STATES OF AMERICA

Registration District No. _____
 State File No. _____
 Prob. Registration District No. _____

I, the undersigned, who used to present Criminal in _____

Charge _____
 Section _____
 Chapter _____
 Article _____

Charge _____
 Section _____
 Chapter _____
 Article _____

Charge _____
 Section _____
 Chapter _____
 Article _____

Charge _____
 Section _____
 Chapter _____
 Article _____

Charge _____
 Section _____
 Chapter _____
 Article _____

Charge _____
 Section _____
 Chapter _____
 Article _____

Charge _____
 Section _____
 Chapter _____
 Article _____

Charge _____
 Section _____
 Chapter _____
 Article _____

Charge _____
 Section _____
 Chapter _____
 Article _____

Charge _____
 Section _____
 Chapter _____
 Article _____

Charge _____
 Section _____
 Chapter _____
 Article _____

Charge _____
 Section _____
 Chapter _____
 Article _____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72487

PLACE OF DEATH

County of Lewis
City of Winchester

Registration District No. 50
Primary Registration District No. 727

Local Registrar's No. 19

(No.)
(If death occurred in a hospital or institution give its name instead of street and number.)

2. FULL NAME Stillbirth

(a) Residence. No. St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year) <u>Oct. 25, 1930</u>		
7. AGE <u>Born dead</u>	Years Months Days	If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (city or town) Winchester, Ida.
(State or country)

PARENTS	10. NAME OF FATHER <u>Chas. W. Hunter</u>
	11. BIRTHPLACE OF FATHER (city or town) <u>Turtle Lake, Wis.</u> (State or Country)
	12. MAIDEN NAME OF MOTHER <u>Laura Prentiss</u>
	13. BIRTHPLACE OF MOTHER (city or town) <u>Asotin Wash.</u> (State or Country)

14. Informant Chas. W. Hunter
(Address) Winchester, Ida.

15. Filed 11/4, 1930 RG Dueson
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 25, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1930, to Oct. 25, 1930
that I last saw her alive on Stillborn, 1930
and that death occurred, on the date stated above, at 8:30 A.M.
The CAUSE OF DEATH* was as follows:
Stillbirth due to Prolapsia of the mother
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18. Where was disease contracted —
if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) A.B. Halliday, M. D.
Oct. 25, 1930 (Address) Winchester, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal <u>Winchester, Ida.</u>	Date of Burial <u>Oct. 25</u> , 19 <u>30</u>
20. Undertaker <u>none</u>	Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OR RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Manitoba
City of Rupert
No. St.

CERTIFICATE OF BIRTH

185779

Registration District No. 19 State File No.
(If born in hospital or institution give name.) Prim. Registration District No. 2015 Local Registrar's No. 157

FULL NAME OF CHILD Thelma
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and {	Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>Oct 14</u> 19 <u>30</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What prophylactic was used to prevent Ophthalmia Neonatorum? Yes. Silver nitrate

Number of child of this mother, including present birth 10 (a) Born alive and now living 8

Born alive but now dead 1 Stillborn 1

FATHER	MOTHER
FULL NAME <u>Francis Noble</u>	FULL MAIDEN NAME <u>Shadig Liteau</u>
Residence (Usual place of abode) <u>Rupert</u>	Residence (Usual place of abode) <u>Rupert</u>
If non-resident, give place and State <u> </u>	If non-resident, give place and State <u> </u>
Color or race <u>White</u> Age at last Birthday <u>41</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>40</u> (Years)
Birthplace <u>Utah</u> (City and State or County)	Birthplace <u>Utah</u> (City and State or County)
Occupation <u>Farmer</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 3 20 P.M.
on the date above stated.

(Signature) E. E. E. E. E.

(Physician or midwife)

Address Rupert

Filed 11-2 1930 E. E. E. E. E.
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

CHILD TO BE A STATE

admission to the service of the State.

12

RESULTS TO BE REPORTED

SECRET
NOV 12 1964

Registration District No. _____
 Registration District No. _____

(This is a scan of a "mirrored" document. The text is reversed.)

(Date) (Month) (Year)

Number of child of this mother, including present birth (a) Born alive and now living

...and the evil men

NAME	CELL	BATHING	FEED	NOTES
NAME	CELL	BATHING	FEED	NOTES

.....

11-10-1964

Color of hair: _____ Color of eyes: _____ Color of skin: _____
(Year) (Year) (Year)

(City and State or County)

CONFIDENTIAL

ENTIRETY OF ATTENDING PHYSICIAN OR MIDWIFE.

10-11-68

(S) (U)

(The following is a list of the names of the persons who have been named in the above report.)

10-10-68

There were no attending physicians or nurses from the latter household, and should make this return. A child was born last night, but neither parent nor mother's name is known.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. 3-19-19. 5-25 M. 1-19.

NOV 6

1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Minidoka
City of RupertRegistration District No. 19Primary Registration District No. 2213

(No. _____ St.)

State File No. 72498Local Registrar's No. 47

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn Noble

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

He

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDsingle
(Write the word)

6. DATE OF BIRTH

Oct. 16 1930
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.IF LESS than 1
day how many
0 hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Stillborn

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Rupert, Idaho

10. NAME OF

Father

Francis Noble

11. BIRTHPLACE

OF FATHER

(State or Country)

Nephi, Utah

12. MAIDEN NAME

OF MOTHER

Gladys Tietz

13. BIRTHPLACE

OF MOTHER

(State or Country)

Nephi, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Francis Noble

(Address)

Rupert, Idaho

15.

Filed

Nov. 41930Ed E. Elmer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 16 1930 to 19,
notthat I last saw him alive on Oct. 16 1930,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)unknown

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Ed E. Elmer M.D.11-4-1930. (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19____

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of MyrtleCity of MyrtleNo. 432-106 035-155 St.Lisa Orcharde(If born in hospital or institution
give name.)

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u> }</u> and <u> }</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Oct 6</u> 19 <u>30</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? ✓Number of child of this mother, including present birth 1 (a) Born alive and now living 1Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>Dennis McKay</u>	MOTHER FULL MAIDEN NAME <u>Lura Jenkins</u>
---	--

Residence (Usual place of abode) <u>Myrtle, Ida</u>	Residence (Usual place of abode) <u>Same</u>
---	--

It non-resident, give place and State <u>W.</u>	It non-resident, give place and State <u>W.</u>
---	---

Color or race <u>W.</u> Age at last Birthday <u>21</u> (Years)	Color or race <u>W.</u> Age at last Birthday <u>16</u> (Years)
--	--

Birthplace <u>Idaho</u> (City and State or County)	Birthplace <u>Washington</u> (City and State or County)
--	---

Occupation <u>Farmer</u>	Occupation <u>Housewife</u>
--------------------------	-----------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 4:30 P. M. on the date above stated.(Signature) J. M. Lyle

(Physician or midwife)

Address Leiston, IdaFiled 11-1-30 J. M. Lyle Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

NOV 8 1930

STATE OF IDAHO

County of Oneida
City of Malad

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

No. _____ St. _____

Registration District No. 26

State File No. 185819

(If born in hospital or institution give name.)

Prim. Registration District No. 2069

Local Registrar's No. 134

FULL NAME OF CHILD

Stillborn Ward

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child

Female

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

Date of
birth

Oct 21

(Month)

(Day)

1930

(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? August

Number of child of this mother, including present birth 5

(a)

Born alive

and

now living

4

Born alive but now dead

0

Stillborn

1

FATHER
FULL
NAME

Jess L. Ward Jr.

Residence (Usual place of abode)

Malad

If nonresident, give place and State

Color or race

white

Age at last Birthday

3 2

(Years)

Birthplace

Hardy, Ida

(City and State or Country)

Occupation

Farmer

MOTHER
FULL
MAIDEN
NAME

Delila Jones

Residence (Usual place of abode)

Malad

If nonresident, give place and State

Color or race

white

Age at last Birthday

26

(Years)

Birthplace

Malad, Ida

(City and State or Country)

Occupation

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was

Born alive

Stillborn

at

4:30 a

M.

on the date above stated.

(Signature)

V. J. Gant

Physician

(Physician or midwife)

Address

Malad, Idaho

Filed 10-31 1930

J. M. Arnes

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

4/ -

4 -

4 -

4 -

4 -

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72522

PLACE OF DEATH

County of OneidaCity of MaladRegistration District No. 26Primary Registration District No. 2069Local Registrar's No. 40

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Steel King Ward(a) Residence. No. Malad Id. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Child</u>
-------------------------	----------------------------------	--

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Oct. 21-30

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
<u>Steel Born</u>				

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Malad
(State or country)10. NAME OF FATHER Jess L Ward11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Malad Idaho12. MAIDEN NAME OF MOTHER Delila Jones13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Malad14. Informant Jess L Ward
(Address) Malad Ida.15. Filed 10-31-30 J. M. Keres
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 21 1930
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Oct. 21, 1930, to _____, 19____
that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

still born.

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted ☒
if not at place of death?Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis?

(Signed) V. P. Gayst, M. D.Oct. 22, 1930 (Address) Malad, Idaho*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.19. Place of Burial, Cremation, or Removal Malad Ida Date of Burial Oct. 21 193020. Undertaker J. L. Hansen Address Malad Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Salesman, (b) Grocery;** (a) **Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary) intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Idiopathic," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicæmia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning struck by railway train—accident; Revolver wound head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to a lawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return up to the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH *Idaho* NOV 8 1930
County of *Blaine*
City of *Idaho*
No. St.
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
Registration District No. *26* State File No. *185829*
Local Registrar's No. *114*

FULL NAME OF CHILD *Stillborn*

(If stillborn, substitute the word "Stillbirth" for name of child)
Sex of Child *Male* Twin Triplet or other? *and* Number in order of birth *1* Legitimate *Yes* Date of birth *Sept. 4* 1930
(To be answered only in event of plural births) (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? *Stillborn*

Number of child of this mother, including present birth *2* (a) Born alive and now living *1*
Born alive but now dead *1* Stillborn *0*

FATHER	MOTHER
FULL NAME <i>Alfred Louis Papey</i>	FULL MAIDEN NAME <i>Trilla Stead</i>
Residence (Usual place of abode) <i>Idaho</i>	Residence (Usual place of abode) <i>Idaho</i>
If nonresident, give place and State	If nonresident, give place and State
Color or race <i>White</i> Age at last Birthday <i>35</i> (Years)	Color or race <i>White</i> Age at last Birthday <i>24</i> (Years)
Birthplace <i>Idaho</i> (City and State or Country)	Birthplace <i>Clinton Utah</i> (City and State or Country)
Occupation <i>Farmer</i>	Occupation <i>Housewife</i>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was *Stillborn* at *Idaho* on the date above stated. (Signature) *Edmund B. ...*

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address *Snowville Utah*
Filed *10-51* 1930 *M. K. ...* Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED NOV 6 1930
County of Yuba Falls
City of Yuba Falls
No. 17 Co + Gen. Hosp. St. _____
Registration District No. 37 State File No. 185895
(If born in hospital or institution give name.) Prim. Registration District No. 2283 Local Registrar's No. 429
FULL NAME OF CHILD Stell Horn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>yo</u>	Date of birth <u>Oct 1 1930</u> (Month) (Day) (Year)
----------------------------	------------------------------	-----------	--------------------------------	-----------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? Silver nitrate
Number of child of this mother, including present birth 2 (a) Born alive and now living 2
Born alive but now dead 0 Stillborn 0

FATHER	MOTHER
FULL NAME <u>Herman Charles Stanfield</u>	FULL MAIDEN NAME <u>Ruby Ellen Claycomb</u>
Residence (Usual place of abode) <u>Buhl, Ida.</u>	Residence (Usual place of abode) <u>Buhl, Ida.</u>
It non-resident, give place and State _____	It non-resident, give place and State _____
Color or race <u>W.</u> Age at last Birthday <u>28</u> (Years)	Color or race <u>W.</u> Age at last Birthday <u>25</u> (Years)
Birthplace <u>Vincennes Indiana</u> (City and State or County)	Birthplace <u>Johnstown Colo.</u> (City and State or County)
Occupation <u>Farmer</u>	Occupation <u>Home wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 6:40 P. M.
on the date above stated.
(Signature) Geo. Jennings
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Buhl Ida.
Filed Nov 10 1930 Elizabeth J. Smith
Registrar.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 72559

PLACE OF DEATH

County of Twin Falls
City of Twin Falls

CERTIFICATE OF DEATH

Registration District No. 37

Primary Registration District No. 2085

Local Registrar's No. 172

(No. Twin Falls County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

Jennie Louise Stanfield

26

(a) Residence No. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,
or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

0

0

0

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work

none

(b) General nature of industry,
business, or establishment in
which employed (or employer)

"

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Twin Falls Ida

10 NAME OF FATHER

Herman Stanfield

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Indian

12 MAIDEN NAME OF MOTHER

Ruby Claycomb

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Colorado

PARENTS

14 Informant

(Address)

H. Stanfield
Buhl Ida R.F.D. 5

15

Filed Oct. 16, 1930

Elizabeth J. Smith

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 6

1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from
10-6-, 1930, to 10-6-, 1930.

that I last saw h. on not living, 1930.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Detached placenta with
hemorrhage

(duration) _____ yrs. _____ mos. 3 ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. J. Downing, M. D.

10-7-, 1930 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Twin Falls Ida

10-8 1930

20. Undertaker

Address

White Mortuary

Twin Falls
Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

442-223 042-168
PLACE OF BIRTH RECEIVED
County of Twin Falls
City of Twin Falls
No. 752-2 and Ann East
Private Sanatorium
(If born in hospital or institution give name.)

NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. 37 State File No. 185901

Prim. Registration District No. 1085 Local Registrar's No. 422

FULL NAME OF CHILD Barbara Elizabeth Duke
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>—</u>	and { Number in order of birth <u>—</u>	Legitimate? <u>Yes</u>	Date of birth <u>Sept 23 1930</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth one (a) Born alive and now living no born dead
Born alive but now dead Born dead Stillborn —

FATHER
FULL NAME Jesse Lynn Duke
Residence (Usual place of abode) Twin Falls
If nonresident, give place and State —
Color or race White Age at last Birthday 23 (Years)
Birthplace Santaquin Utah
(City and State or Country)
Occupation Operator news

MOTHER
FULL MAIDEN NAME Haddene Vella Johnson
Residence (Usual place of abode) —
If nonresident, give place and State Twin Falls
Color or race White Age at last Birthday 23 (Years)
Birthplace Mountain Pleasant Utah
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive on the date above stated. Stillborn } at 7:45 P. M.

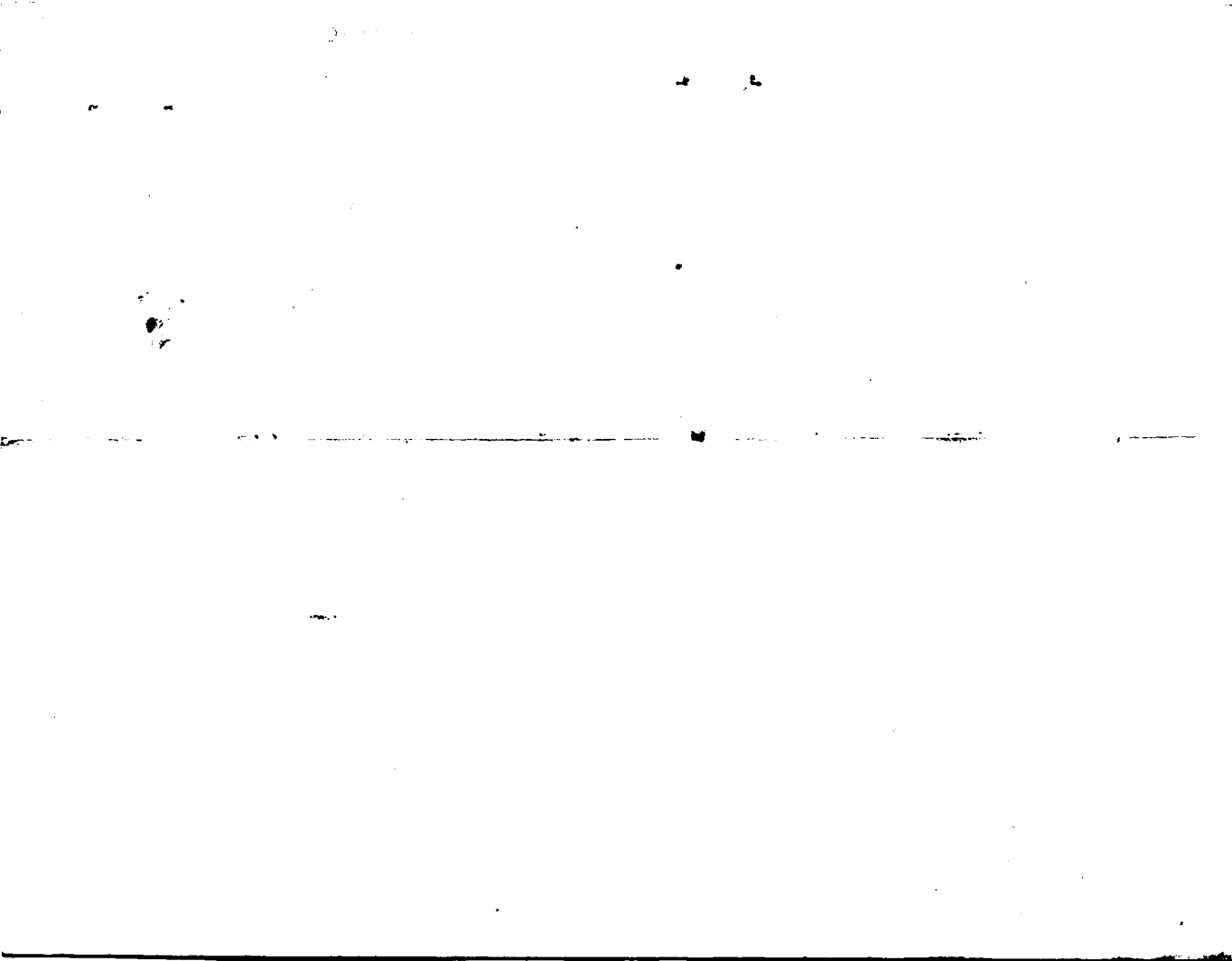
(Signature) E. Lamb

(Physician or midwife)

Address Twin Falls Idaho

Filed Oct. 29 1930 Elizabeth J. Smith Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

OCT 14 1930
 PLACE OF DEATH
 County *Blaine Falls*
 City of *Blaine Falls*

STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

Registration District No. *37*
 Primary Registration District No. *1085*

DO NOT WRITE IN THIS SPACE

State File No. *72190*Local Registrar's No. *160*

(If death occurred in a hospital or institution, give its name instead of street and number.)
 2. FULL NAME *Barbara Duke*
 (a) Residence. No. *103 Reed apt* St. *Blaine Falls*
 (Usual place of abode)
 Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX *Fe* 4. COLOR OR RACE *White* 5. Single, Married, Widowed, or Divorced (write the word) *Single*
 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of *Still Born*
 6. DATE OF BIRTH (month, day and year) *Sept 22 / 1930*
 7. AGE Years Months Days If LESS than 1 day, hrs. or min.
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work.
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (city or town) (State or country) *Idaho*10. NAME OF FATHER *J. Duke*11. BIRTHPLACE OF FATHER (city or town) (State or Country) *Idaho*12. MAIDEN NAME OF MOTHER *Hallene Johnson*13. BIRTHPLACE OF MOTHER (city or town) (State or Country) *Idaho*14. Informant *J. Duke*
(Address) *103 Reed apt. St. Blaine Falls*15. Filed *Sept 27, 1930* *Elyse J. Smith* Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Sept. 22* 19 *30*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw h. *Still born* to *have*, 19 *30*
 and that death occurred, on the date stated above, at *Blaine Falls* m.
 The CAUSE OF DEATH* was as follows:
Still born cause

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? *—*Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *H. P. Lamb* M. D.*Sept 22 1930* (Address) *Blaine Falls*

*State the DISEASE CAUSING DEATH, or in deaths from ACCIDENTAL CAUSES state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal *Blaine Falls* Date of Burial *Sept 23 1930*20. Undertaker *Blaine Falls* Address *Blaine Falls*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Salesman, (b) Grocery;** (a) **Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

County of Twin Falls
City of Twin Falls

No. SL
17. W. M. Hosp

Registration District No. 37
Prim. Registration District No. 2085 Local Registrar's No. 451

(If born in hospital or institution give name.)

FULL NAME OF CHILD Still born
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Oct. 29</u> 19 <u>30</u>
(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME <u>Harold M. Miller</u>	FULL MAIDEN NAME <u>Effie May Allen</u>
Residence (Usual place of abode) <u>Hammer</u>	Residence (Usual place of abode) <u>Hammer</u>
If non-resident, give place and State _____	If non-resident, give place and State _____
Color or race <u>W.</u> Age at last Birthday <u>19</u> (Years)	Color or race <u>W.</u> Age at last Birthday <u>19</u> (Years)
Birthplace <u>Berryville Ark.</u> (City and State or County)	Birthplace <u>Berryville Ark.</u> (City and State or County)
Occupation <u>Labor</u>	Occupation <u>House wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 8:13 a. M. on the date above stated.

(Signature) W. C. McCracken
Twin Falls, Idaho
(Physician or 22222)

Address Twin Falls, Idaho

Filed Nov. 1 19 30 E. J. Smith Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



2

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72547

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. 37

Primary Registration District No. 2085

(No. County Gen. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 187

2. FULL NAME Baby Miller

(a) Residence. No. Hansen, Ida. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

10. NAME OF FATHER Harold M. Miller Ark.

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER Effa Allen Ark.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Harold M. Miller (Address) Hansen, Idaho.

15. Filled Nov/5/30 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

14. DATE OF DEATH

Oct. 29th. 30
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Oct 28 1930 to Oct 29 1930

that I last saw a ~~positive~~ on 1930 and that death occurred, on the date stated above, at 813 AM

The CAUSE OF DEATH* was as follows:

Still born
Premature
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted? If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. G. Newberry, M. D. 10/29/30 (Address) Filer, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial
Twin Falls, Ida. Oct. 30 193020. Undertaker Address
P. H. Grossman Twin Falls, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

NOV 1 1980

PLACE OF BIRTH
County of Washington
City of Wenatchee
No. 5-12- St. 313
593-202-044
(If born in hospital or institution give name.)
Registration District No. 86 State File No. 185960
Prim. Registration District No. 1010 Local Registrar's No. 35
FULL NAME OF CHILD Frankie Lew. Nichols
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>Oct. 2nd</u> 19 <u>80</u> (Month) (Day) (Year)
----------------------------	-----------------------------------	-----------------------------------	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth one (a) Born alive and now living None
Born alive but now dead None Stillborn one

FULL NAME <u>Frank Nichols</u> FATHER Residence (Usual place of abode) <u>Wenatchee, Idaho</u> If non-resident, give place and State <u>Wenatchee, Idaho</u> Color or race <u>White</u> Age at last Birthday <u>27</u> (Years) Birthplace <u>Idaho</u> Occupation <u>R.R. Motor man</u>	FULL MAIDEN NAME <u>Opal Calkins</u> MOTHER Residence (Usual place of abode) <u>Wenatchee, Idaho</u> If non-resident, give place and State <u>Wenatchee, Idaho</u> Color or race <u>White</u> Age at last Birthday <u>23</u> (Years) Birthplace <u>Idaho</u> Occupation <u>Housewife</u>
---	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 8. P. M. on the date above stated.

(Signature) M. R. Hamilton
Physician
(Physician or midwife)

Address Wenatchee, Idaho
Filed Oct 15 1980 by M. R. Hamilton

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

ORIGINAL OF THIS DOCUMENT IS IN THE POSSESSION OF THE BUREAU OF THE INSPECTION OF THE DEPARTMENT OF JUSTICE

DEPARTMENT OF JUSTICE
BUREAU OF THE INSPECTION
WASHINGTON, D. C.

Investigation conducted by
Special Agent in Charge
[Name]

DATE OF REPORT

FILE NUMBER

NAME OF SUBJECT
[Name]
[Address]
[City, State, Zip]

What information was used to prepare this report?

Number of this report, including previous reports

Form also not used

NAME OF SUBJECT
[Name]
[Address]
[City, State, Zip]

What information was used to prepare this report?

Number of this report, including previous reports

Form also not used

NAME OF SUBJECT
[Name]
[Address]
[City, State, Zip]

What information was used to prepare this report?

Number of this report, including previous reports

Form also not used

NAME OF SUBJECT
[Name]
[Address]
[City, State, Zip]

What information was used to prepare this report?

Number of this report, including previous reports

Form also not used

NAME OF SUBJECT
[Name]
[Address]
[City, State, Zip]

What information was used to prepare this report?

Number of this report, including previous reports

Form also not used

There were no other persons
or individuals (other than the subject)
who should be included in this report.
Child is one that neither parent nor
other relatives of the father birth

(Signature of subject)

Address

City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC NOV 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72582

PLACE OF DEATH
County of Washington
City of Wenatchee

Registration District No. 86
Primary Registration District No. 1010

Local Registrar's No. 13

(No. _____)
(If death occurred in a hospital or institution give its name instead of street and number.)

2. FULL NAME Frankie Lou Nichols

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE Wt 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct-27-1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Wenatchee
(State or country) Idaho

10. NAME OF FATHER Frank Nichols

11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Opal Colkins

13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant Frank Nichols
(Address) Wenatchee Idaho

15. Filed Oct. 13, 1930 W. R. Hamilton
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 27, 1930, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) W. R. Hamilton, M. D.
Oct 27, 1930 (Address) Wenatchee

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Helleret Cemetery Date of Burial 10-30-1930

20. Undertaker L. B. Northrup Address Wenatchee

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

289 112 203 864
PLACE OF BIRTH IN DEC 3 1930
County of Barnes
City of Bancroft
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

186031

Registration District No. 84 State File No. _____

Prim. Registration District No. 2161 Local Registrar's No. 839

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate	Date of birth	(Month)	(Day)	(Year)
				<u>Nov 12</u>			<u>1930</u>

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 6 (a) Born alive and now living 3

Born alive but now dead _____ Stillborn 3

FATHER FULL NAME <u>Roy L. Byington</u>	MOTHER FULL MAIDEN NAME <u>Florence Housely</u>
--	--

Residence (Usual place of abode) Bancroft

If nonresident, give place and State _____

Color or race White Age at last Birthday 39 (Years)

Birthplace Idaho (City and State or Country)

Occupation Farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3:30 P. M. on the date above stated.

(Signature) E. G. Galt

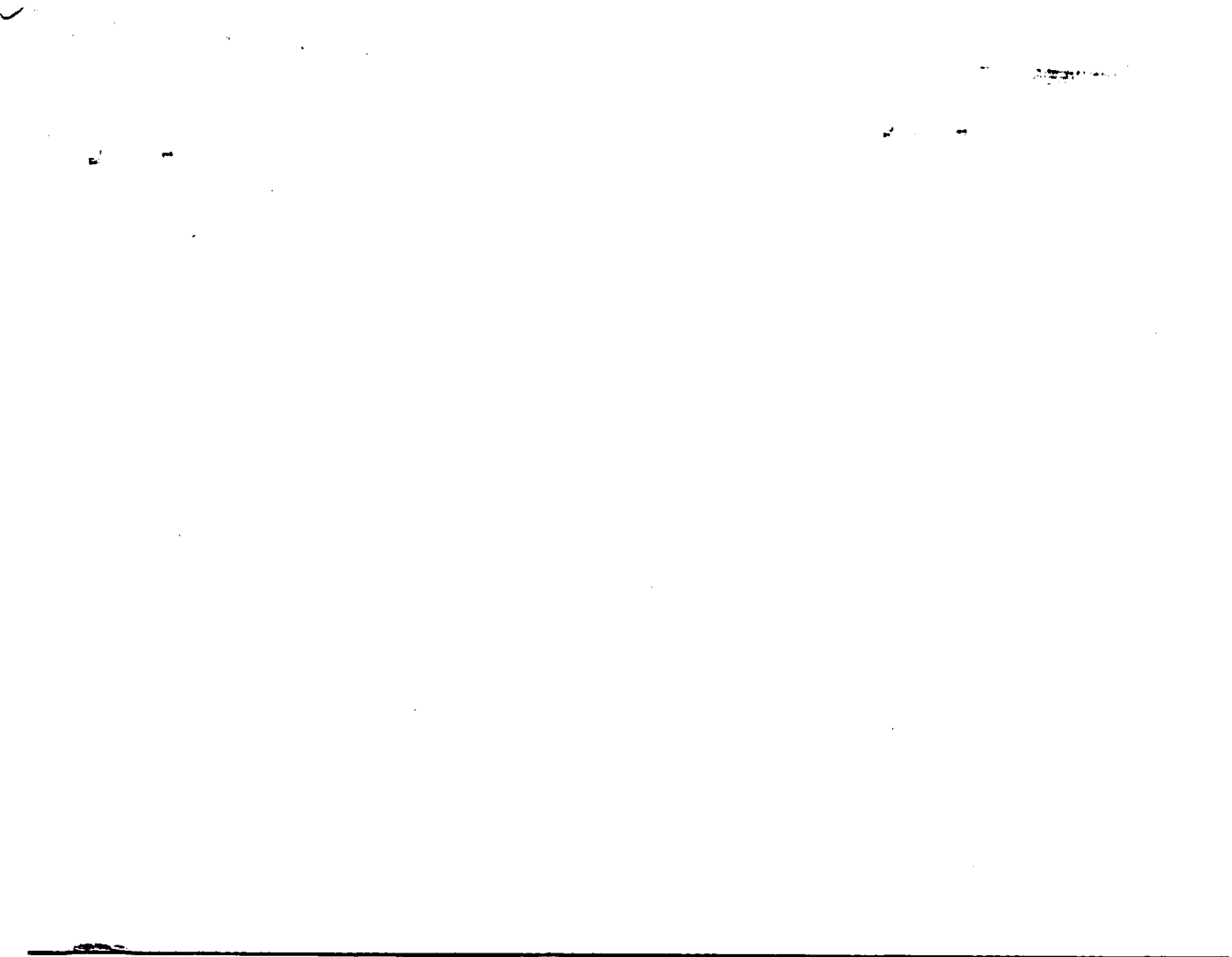
(Physician or midwife)

Address Bancroft Idaho

Filed Dec 1 - 1930 Mrs. E. G. Galt

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

72620

State File No.

Local Registrar's No. 194

PLACE OF DEATH

County of Bannock
City of Bancroft Ida

CERTIFICATE OF DEATH

Registration District No. 8-4Primary Registration District No. 2161

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Byington

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

(If nonresident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Whitesingle

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

Nov-12-1939

7 AGE

Years

Months

Days

Stillbirth

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bancroft Ida
(State or country)10 NAME OF FATHER Roy L. Byington11 BIRTHPLACE OF FATHER (city or town) Idaho
(State or country)12 MAIDEN NAME OF MOTHER Florence Housley13 BIRTHPLACE OF MOTHER (city or town) Utah
(State or country)

14

Informant Roy L. Byington
(Address) Bancroft Ida

15

Filed Dec-13, 1930Mr. G. G. Fit

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov-12,
(Month) (Day)1930
(Year)17 I HEREBY CERTIFY, That I attended deceased from Stillbirth, 19____, to _____, 19____,

that I last saw him alive on _____, 19____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

StillbirthCONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) E. G. FitzNov-13, 1930(Address) Bancroft Ida

M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Lava Hot SpringsNov 13 1930

20. Undertaker

Address

Had none

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Blaine

City of Pocatello

No. 1212 E Clark St.

St Anthony
(If born in hospital or institution
give name.)

FULL NAME OF CHILD

Registration District No. 28 State File No. 186040

Prim Registration District No. 2141 Local Registrar's No. 10109

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>Nov 26</u> 19 <u>30</u>
(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 2

Born alive but now dead 2 Stillborn 1

FATHER FULL NAME <u>James L Brown</u>	MOTHER FULL MAIDEN NAME <u>Ola Clifford</u>
--	--

Residence (Usual place of abode) <u>Pocatello</u>	Residence (Usual place of abode) <u>Pocatello</u>
---	---

If non-resident, give place and State	If non-resident, give place and State
---------------------------------------	---------------------------------------

Color or race <u>White</u>	Age at last Birthday <u>39</u> (Years)	Color or race <u>White</u>	Age at last Birthday <u>35</u> (Years)
----------------------------	--	----------------------------	--

Birthplace <u>Utah</u>	(City and State or County)	Birthplace <u>Idaho</u>	(City and State or County)
------------------------	----------------------------	-------------------------	----------------------------

Occupation <u>Railroad Employ</u>	Occupation <u>Housewife</u>
-----------------------------------	-----------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 12 noon M. on the date above stated.

(Signature) Dr. J. P. Swann

(Physician or midwife)

Address Pocatello Idaho

Filed 12/1 1930 W. H. Manning Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

SECRET

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

SECRET

REF ID: A71072

100-411410-100

...of

It is further stated that the word "Bible" is used in the title of the book.

1970-11-10

10-10-68

1. The first part of the document is a list of names and titles, including "The Honorable" and "The Right Honorable".

1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.

Number 10-11 of his finger including present birth

.....

RENTON 1-12 1944

ALBANY, N.Y., May 12 (AP) —

[Faint, illegible text at the bottom of the page]

1944-1945

[Faint, illegible markings]

5705

[illegible]

Occupation

OFFICE OF THE ATTORNEY GENERAL

SECRET

14

(914) 640-1100

[illegible]

...the latter, however...

PROF. A. L. LITVIN

...and is the only person who has been able to...

01-1-101

There were no attending physicians at the time of the father's death. A physician was called to the house after the death of the child in order to examine the child.

STATE OF IDAHO

RECEIVED DEC 8 1930

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 72622

PLACE OF DEATH

County of BennettCity of Pocatello

CERTIFICATE OF DEATH

Registration District No. 28Primary Registration District No. 27161 Local Registrar's No. 5948

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn Baby Brown(a) Residence. No. 1212 E. Clark St.

(Usual place of abode.)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word.)5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) 11/26/307. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello
(State or country)10. NAME OF FATHER Los L. Brown11. BIRTHPLACE OF FATHER (city or town) Salt Lake City
(State or Country)12. MAIDEN NAME OF MOTHER Ellen Clifford13. BIRTHPLACE OF MOTHER (city or town) Scott Idaho
(State or Country)14. Informant (Address) Los L. Brown
Pocatello15. Filed 11/27 1930 Sperry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 26 1930
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 11/26 1930, to 11/26 1930
that I last saw him alive Stillborn 1930
and that death occurred, on the date stated above, at _____ m.*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Stillborn

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? No Date of +Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. J. Brown M. D.
11/26/30 1930 (Address) Pocatello19. Place of Burial, Cremation, or Removal Rigby Id Date of Burial 11/27 193020. Undertaker J. J. Brown Address Pocatello
2010

PHYSICIAN

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.,** of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS, state MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

145-1135-293-381
PLACE OF BIRTH DEC 8 1930
County of Paria

City of Paratella

No. 1229 N. Hayes St.

Paratella, Ind.

(If born in hospital or institution give name.)

FULL NAME OF CHILD

Still born

(If stillborn, substitute the word "Stillbirth" for name of child)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

186059

Registration District No. 28 State File No. 101090

Prim. Registration District No. 214 (Local Registrar's No. 101090)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>11-13-1930</u> (Month) (Day) (Year)
--------------------------	-----------------------------------	-----------------------------------	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth X (a) Born alive and now living X

Born alive but now dead Stillborn 1

FATHER
FULL NAME Harry W. Amundson

Residence (Usual place of abode) 1229 N. Hayes St.

If non-resident, give place and State

Color or race W Age at last Birthday 31 (Years)

Birthplace Paratella, Ind.
(City and State or County)

Occupation R.R.

MOTHER
FULL MAIDEN NAME Evelyn Crane

Residence (Usual place of abode) 1229 N. Hayes St.

If non-resident, give place and State

Color or race W Age at last Birthday 29 (Years)

Birthplace Montpelier, Idaho
(City and State or County)

Occupation House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 7 P M. on the date above stated.

(Signature) W. B. Brothers

(Physician or midwife)

Address Paratella, Ind.

Filed 12/1 1930 W. B. Brothers
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

It bore there was an attending physician
or midwife when the latter, householder
etc. should make this return. A billborn
child is one that neither physician nor
other evidence of life after birth.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was born on the date above stated.

(Signature)

Address

Printed

Registration No.

Occupation

(City and State or County)

(Year)

Birthplace (City, State or County)

Occupation

Birthplace

Age at last birthday

Color or race

If born within five days of date

Weight (in pounds)

Weight (in pounds)

Birth

After

Birth

NO TIME

Birth (in case of twins, but not born)

Birthplace

Number of child of this mother, including present birth (a) Born alive and now living

What physicians and nurses were present (Physician's Name)

(If deceased, state in what hospital)

Weight

Length

Number

Child

(If stillborn, state the cause of death)

Birth Registration District No.

Registration District No.

Date

RECEIVED DEC 8 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 72631

PLACE OF DEATH

County of Bannock

CERTIFICATE OF DEATH

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5939

(No. Pocatello General Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME David Harry Amundsen

(a) Residence. No. Pocatello, Idaho.

St. 5

(If nonresident give city or town and State.)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. Single, Married, Widowed, or Divorced (write the word.) Single
----------------	---------------------------	--

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 13, 1930.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
Still-Born			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello, Idaho.
(State or country)

10. NAME OF FATHER

Harry W. Amundsen

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

Pocatello, Idaho.

12. MAIDEN NAME OF MOTHER

Margaret Evelyn Crane

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

Montpelier, Idaho.

14. Informant Harry W. Amundsen

(Address) 1221 North Hayes Ave. Poca., Ida.

15. Filed 11/14/30. 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 13, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13, 1930, to Nov 13, 1930

that I last saw him alive on Stillborn, 19

and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. W. Grothues M. D.
11/14/30. 19 (Address) Poca., Ida.19. Place of Burial, Cremation, or Removal
Mountain View Cemetery
Pocatello, Idaho.

Date of Burial

11/14/30. 19

20. Undertaker

Arthur W. Hall

Address

Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Saleman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile Factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications. as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home**, who are engaged in the duties of the household only (not paid **House-keepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At Home**, and children not gainfully employed, as **At school or At Home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia**; **Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.**, **Carcinoma, Sarcoma, etc.**, of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping Cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

45-1-107003849

PLACE OF BIRTH

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

86068

County of Blaine
City of Pocatello
No. 7 City 7 Fish Hatchery
Pocatello Registration District No. 28 State File No. _____
(If born in hospital or institution
give name.) Prim. Registration District No. 2161 Local Registrar's No. 10081
FULL NAME OF CHILD Sheelaw Meader
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>-</u>	and {	Number in order of birth <u>-</u>	Legiti- mate? <u>ye</u>	Date of birth <u>Nov. 7</u> 19 <u>30</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth. _____ (a) Born alive and now living. _____

Born alive but now dead. 2 Stillborn 1

FATHER FULL NAME <u>Warren S. Meader</u>	MOTHER FULL MAIDEN NAME <u>Mar Hurrelle</u>
---	--

Residence (Usual place of abode) 7 Fish Hatchery 7 City

It non-resident, give place and State. _____

Color or race White Age at last Birthday 46 (Years)

Birthplace Penn. (City and State or County)

Occupation Truck Cultivator

It non-resident, give place and State. _____

Color or race White Age at last Birthday 30 (Years)

Birthplace Inlet Wisconsin (City and State or County)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 7 M.
on the date above stated.

(Signature) D C Ray

(Physician or midwife)

Address Pocatello

Filed 12/1 1930 J. J. Jones

Registrar

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

STATE OF NEW YORK
IN SENATE
January 1, 1911

REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1909

ALBANY:
J. B. LEECH, PRINTERS
1911

THE LAND OFFICE OF THE STATE OF NEW YORK
HAS THE HONOR TO ACKNOWLEDGE THE RECEIPT OF
A RESOLUTION PASSED BY THE SENATE
MAY 1, 1909, RELATIVE TO THE
LANDS BELONGING TO THE STATE
AND TO REPORT THEREON TO THE SENATE
AT ITS NEXT SESSION.

THE LANDS BELONGING TO THE STATE
ARE OF VARIOUS KINDS, AND ARE
LOCATED IN DIFFERENT PARTS OF THE STATE.
THEY ARE OF GREAT VALUE, AND ARE
WELL SITUATED FOR DEVELOPMENT.
THEY ARE OF GREAT VALUE, AND ARE
WELL SITUATED FOR DEVELOPMENT.

THE LANDS BELONGING TO THE STATE
ARE OF VARIOUS KINDS, AND ARE
LOCATED IN DIFFERENT PARTS OF THE STATE.
THEY ARE OF GREAT VALUE, AND ARE
WELL SITUATED FOR DEVELOPMENT.
THEY ARE OF GREAT VALUE, AND ARE
WELL SITUATED FOR DEVELOPMENT.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

NOV 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72270

PLACE OF DEATH
County of Bannock
City of Pocaters

Registration District No. 28
Primary Registration District No. 2161

Local Registrar's No. 5934

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)
2. FULL NAME Infant (Meader)
(a) Residence. No. W. S. Meader St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS			
3. SEX <u>Male</u>	4. COLOR AND RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>	
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____			
6. DATE OF BIRTH (month, day and year) <u>Nov 7-1930</u>			
7. AGE <u>Still Born</u>		If LESS than 1 day, hrs. or min.	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____			
9. BIRTHPLACE (city or town) (State or country) <u>Pocaters Idaho</u>			
10. NAME OF FATHER <u>W. S. Meader</u>			
11. BIRTHPLACE OF FATHER (city or town) (State or Country) <u>Penn</u>			
12. MAIDEN NAME OF MOTHER <u>May Humelle</u>			
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) <u>Wis</u>			
14. Informant <u>W. S. Meader</u> (Address) <u>Pocaters Idaho</u>			
15. Filled _____, 19____ Registrar _____			

MEDICAL CERTIFICATE OF DEATH	
16. DATE OF DEATH <u>Nov 7</u>	<u>30</u> 19____ (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to <u>Nov 7</u> , 19 <u>30</u> that I last saw him alive on _____, 19____ and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Sudden intra-abdominal hemorrhage</u> (duration) _____ yrs. _____ mos. _____ ds.	
CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds.	
18. Where was disease contracted if not at place of death? _____ Did an operation precede death? _____ Date of _____ Was there an autopsy? _____ What test confirmed diagnosis? _____ (Signed) <u>D. C. Ray</u> , M. D. _____, 19____ (Address)	
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
19. Place of Burial, Cremation, or Removal <u>Mountain View</u>	Date of Burial <u>Nov 7</u> 19 <u>30</u>
20. Undertaker <u>Schumacher & Meader</u>	Address <u>Idaho</u>

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

168-126 003-995
PLACE OF RECEIVED

DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock
City of Pocatello

CERTIFICATE OF BIRTH

186094

No. _____ St. _____

Registration District No. 28 State File No. _____

(If born in hospital or institution
give name.)

Prim. Registration District No. 2161 Local Registrar's No. 10055

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>Sept 26</u> <u>1930</u> (Month) (Day) (Year)
--------------------------	------------------------------	-----------	--------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth. 4 (a) Born alive and now living. 3

Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>S. Orval Johnson</u>	MOTHER FULL MAIDEN NAME <u>Lulu Elizabeth Ziehr</u>
---	--

Residence (Usual place of abode) no. 7 City no. 7 City

If non-resident, give place and State _____

Color or race White Age at last Birthday 36 29
(Years) (Years)

Birthplace David City, Neb. La Hogue, Ind.
(City and State or County) (City and State or County)

Occupation farmer farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn Housewife at 5.9 M.
on the date above stated.

(Signature) D. C. Ray

(Physician or midwife)

Address Pocatello

Filed 17 1930 Ray
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

186004

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. _____
This Registration District No. _____

Child's name as given at birth _____
Date of birth _____
Place of birth _____
Sex _____

Parents' names as given at birth _____
Both alive and now _____

Father's name _____
Mother's name _____
Child's name as given at birth _____

Place of birth _____
Date of birth _____
Sex _____

Occupation _____
Place of birth _____
Date of birth _____

Signature of attending physician or midwife _____
Date _____

Signature of registrar _____
Date _____

Address _____
City _____

CERTIFICATE OF CHILD

Child's name as given at birth _____
Date of birth _____
Place of birth _____
Sex _____

Parents' names as given at birth _____
Both alive and now _____

Father's name _____
Mother's name _____
Child's name as given at birth _____

Place of birth _____
Date of birth _____
Sex _____

Occupation _____
Place of birth _____
Date of birth _____

Signature of attending physician or midwife _____
Date _____

Signature of registrar _____
Date _____

Address _____
City _____

It is hereby certified that I attended the birth of this child, who was born _____
on the _____ day of _____, 19____.

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 71969

PLACE OF DEATH

County of Bannock
City of Pocatello

CERTIFICATE OF DEATH

Registration District No. 28
Primary Registration District No. 2191
(No. Tuphlee, Idaho)

Local Registrar's No. 5408

2. FULL NAME

(a) Residence. No.

St.

(Usual place of abode.)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 26. 30

7. AGE Stillborn Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello
(State or country) Ida

10. NAME OF FATHER S. O. Johnson

11. BIRTHPLACE OF FATHER (city or town) Nebraska
(State or Country)

12. MAIDEN NAME OF MOTHER Lulu Zieher

13. BIRTHPLACE OF MOTHER (city or town) Iowa
(State or Country)

14. Informant (Address) S. O. Johnson
Pocatello

15. Filed Sept 26 1930 Registrar McDonnell

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26, 1930

that I last saw him alive on Sept 26, 1930
and that death occurred, on the date stated above, at 11:30 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH was as follows:

Stillbirth
monstrous

CONTRIBUTORY
(Secondary)

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. C. Ray M. D.
9-26-1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal Pocatello Date of Burial Sept 26 1930

20. Undertaker McDonnell Address Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

PHYSICIAN

PARENTS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as Day laborer. Farm laborer. Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid House-keepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same ac-

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

cepted term for the same disease. Examples: Cerebro spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "croup"); Typhoid Fever (never report Typhoid pneumonia); Lobar Pneumonia; Bronchopneumonia ("pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of Bingham **RECEIVED DEC 5 1930**
City of Blackfoot, Idaho
No. R.F.D. # I St. 515-227 006 313
(If born in hospital or institution
give name.)
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
Registration District No. 121 State File No. 186142
Prim. Registration District No. 2184 Local Registrar's No. 363

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mately <u>Yes</u>	Date of birth <u>November 27</u> <u>1930</u> (Month) (Day) (Year)
----------------------------	---	---	------------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth Four (a) Born alive and now living Three
Born alive but now dead One none. Stillborn One

FATHER
FULL NAME Hans A. Nansen
Residence (Usual place of abode) Blackfoot, Idaho
If nonresident, give place and State _____
Color or race White Age at last Birthday 40
Birthplace Soda Springs, Idaho (Years)
(City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Katie Talme
Residence (Usual place of abode) Blackfoot, Idaho
If nonresident, give place and State _____
Color or race White Age at last Birthday 36
Birthplace Soda Springs, Idaho (Years)
(City and State or Country)
Occupation House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 7:30 P. M.
on the date above stated.

(Signature) [Signature]

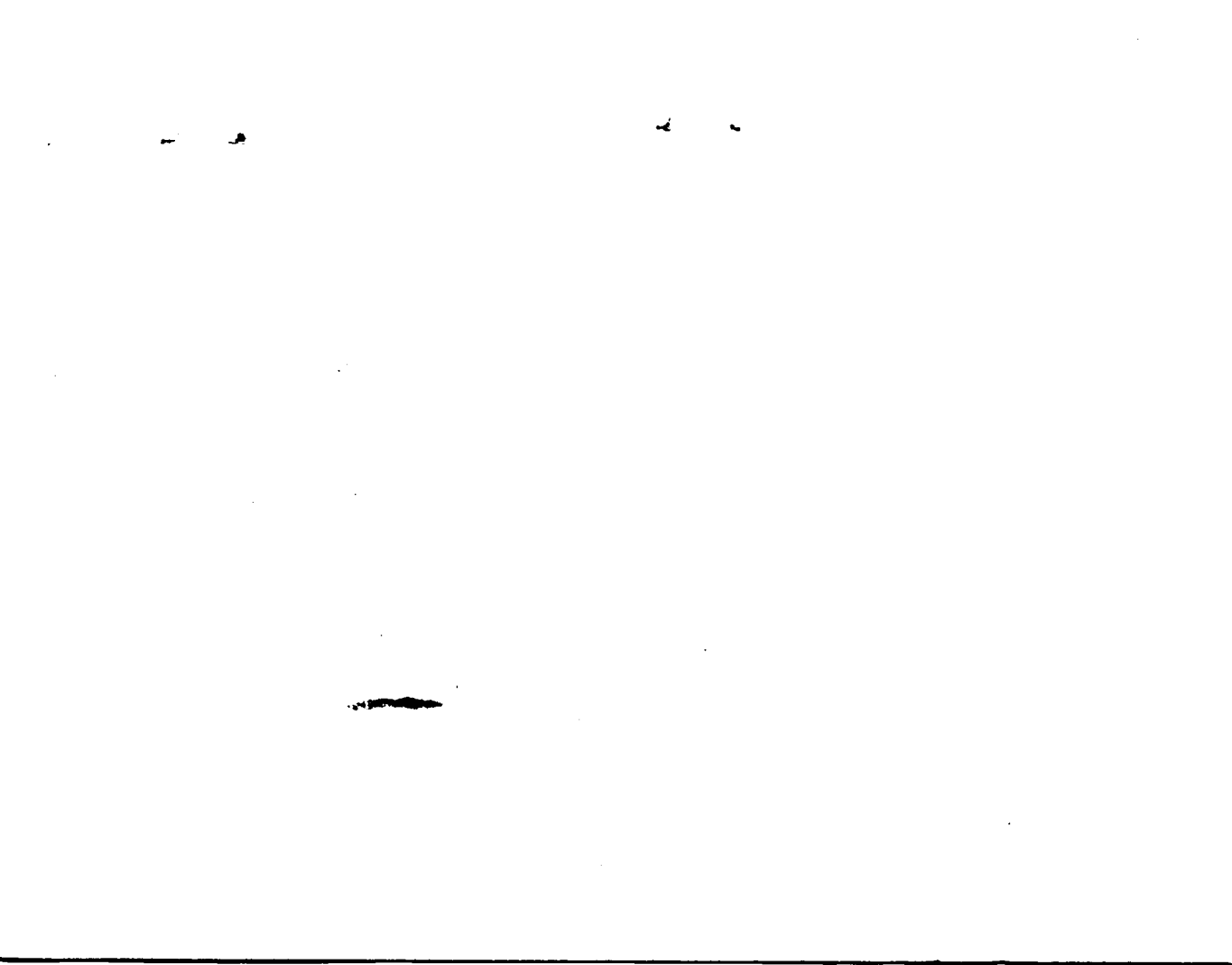
(Physician or midwife)

Address Blackfoot, Idaho

Filed Dec. 2 1930 Mrs. Helen E. Dutton

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
Physician should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

72641

State File No.

- PLACE OF DEATH

County of BinghamCity of Bingham

CERTIFICATE OF DEATH

Registration District No. 121Primary Registration District No. 2194Local Registrar's No. 173

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wm named Hansen(a) Residence No. 112 Mrs. Mrs. Blackfoot

(Usual place of abode.)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

(If nonresident give city or town and State.)
How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE White	5. Single, Married, Widowed, or Divorced (write the word.) Single
------------------	---------------------------	---

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Still born	Years	Months	Days	If LESS than 1 day, hrs. or min.
----------------------	-------	--------	------	--

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Blackfoot, Idaho
(State or country)10. NAME OF FATHER
Hans A. Hansen11. BIRTHPLACE OF FATHER (city or town) Soda Springs,
(State or Country) Idaho12. MAIDEN NAME OF MOTHER Katie Talmie13. BIRTHPLACE OF MOTHER (city or town) Soda Springs
(State or Country) Idaho14. Informant Hans A. Hansen
(Address) Blackfoot, Idaho15. Filed Nov. 28, 1930 30 Mrs. Talmie
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 27, 1930 to November 27, 1930that I last saw her alive on Nov. 27 1930and that death occurred, on the date stated above, at 8/30 a.m.*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:Still born, Premature at
7 month. Due to fault of
circulation blood.

(duration) yrs. mos. ds.

CONTRIBUTORY Influenza of Mother
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) J. W. Mitchell, M. D.Nov. 28, 1930 (Address) Blackfoot Idaho19. Place of Burial, Cremation, or Removal Hansen Ranch NW. Date of Burial Nov. 28 193020. Undertaker Hans A. Hansen Address Blackfoot

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of (name origin);** "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia, "PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Blaine **RECEIVED NOV 25 1930**

City of Burley

No. 346 S. Higgins St.

296 204 016412

(If born in hospital or institution give name.)

FULL NAME OF CHILD

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S
186219

Registration District No. _____ State File No. _____

Prim. Registration District No. _____ Local Registrar's No. _____

Still birth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and <u> </u>	Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>Oct 4th</u> 19 <u>30</u>
					(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? 0

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 0

FATHER FULL NAME <u>Wallace Alma Brown</u>	MOTHER FULL MAIDEN NAME <u>Phyllis Olga Mahoy</u>
---	--

Residence (Usual place of abode) Burley, Idaho.

If non-resident, give place and State

Color or race White Age at last Birthday 23 (Years)

Birthplace Davis Utah (City and State or County)

Occupation Auto Mechanic

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 12 40 P. M. on the date above stated.

(Signature) Elmer J. Taylor, M.D.

(Physician or midwife)

Address Burley, Idaho.

Filed 11-15-1930 F. H. Carter

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

When there was no attending physician or relative, then the latter, householder, etc. should make this return. A physician's certificate is not required, but should be used that neither practice nor show other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

431-106-027-2449
PLACED IN DEC 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH **S 186304**

County of Jerome
City of Jerome
No. _____ St.

St. Valentine Hospital Registration District No. 18 State File No. _____

(If born in hospital or institution give name.) Prim. Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD - Stillborn -
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u>4</u> and {	Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>Nov 6</u> 19 <u>30</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What prophylactic was used to prevent Ophthalmia Neonatorum? 10% Argyl

Number of child of this mother, including present birth. 4 (a) Born alive and now living 2

Born alive but now dead. _____ Stillborn 2

FATHER FULL NAME <u>David McArthur</u>	MOTHER FULL MAIDEN NAME <u>Emma L Murray</u>
---	---

Residence (Usual place of abode) <u>Jerome Idaho</u>	Residence (Usual place of abode) <u>Jerome Idaho</u>
--	--

If non-resident, give place and State _____	If non-resident, give place and State _____
---	---

Color or race <u>white</u> Age at last Birthday <u>45</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>38</u> (Years)
---	---

Birthplace <u>Utah</u> (City and State or County)	Birthplace <u>Utah</u> (City and State or County)
---	---

Occupation <u>Farming</u>	Occupation <u>House wife</u>
---------------------------	------------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 2 - A M. on the date above stated.

(Signature) Chas H. Zeller
M.D.
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Jerome Idaho
Filed 11/6 1930 Chas H. Zeller

128304

1. Name of child
2. Date of birth
3. Place of birth

4. Name of mother (in full name of mother)

5. Name of father (in full name of father)
6. Name of mother (in full name of mother)
7. Name of father (in full name of father)

8. Name of mother (in full name of mother)
9. Name of father (in full name of father)
10. Name of mother (in full name of mother)

11. Name of father (in full name of father)
12. Name of mother (in full name of mother)
13. Name of father (in full name of father)

14. Name of mother (in full name of mother)
15. Name of father (in full name of father)
16. Name of mother (in full name of mother)

17. Name of father (in full name of father)
18. Name of mother (in full name of mother)
19. Name of father (in full name of father)
20. Name of mother (in full name of mother)

RECEIVED DEC 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 72738

PLACE OF DEATH

County of Jerome

City of Jerome

CERTIFICATE OF DEATH

Registration District No. 18

Primary Registration District No.

Local Registrar's No.

(No. St. Valentine Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby McArthur

(a) Residence. No. St.

(Usual place of abode.)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word.) Infant

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Jerome Idaho (State or country)

10. NAME OF FATHER

David McArthur

11. BIRTHPLACE OF FATHER (city or town) Utah (State or Country)

12. MAIDEN NAME OF MOTHER

Emma L Murray

13. BIRTHPLACE OF MOTHER (city or town) Utah (State or Country)

14. Informant David McArthur (Address) Jerome Idaho

15. Filed 11/6, 1930 Chas F. Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 6 (Month)

6 (Day)

1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 6, 1930, to Nov 6, 1930

that I last saw h. alive on 19

and that death occurred, on the date stated above, at m.

State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. The CAUSE OF DEATH was as follows:

Prolapsed Cord

Forceps delivery

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

(Address) 19

19. Place of Burial, Cremation, or Removal

Date of Burial

20. Undertaker

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications. as **Day laborer Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid House-keepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of** (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Madison
City of PextburgNo. 595-213 033-299 St.(If born in hospital or institution
give name.)FULL NAME OF CHILD Sarah Jane Niederer
(If stillborn, substitute the word "Stillbirth" for name of child)

DEC 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

186390

Registration District No. 100 State File No. _____Prim. Registration District No. 2178 Local Registrar's No. 318

Sex of Child <u>Female</u>	Twin Triplet or other? <u>✓</u> and <u>✓</u> Number in order of birth <u>1</u> (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of birth <u>11-13</u> 19 <u>30</u> (Month) (Day) (Year)
----------------------------	---	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? Silver nitrateNumber of child of this mother, including present birth 8 (a) Born alive and now living 7Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>Arthur Emil Niederer</u>	MOTHER FULL MAIDEN NAME <u>Mary Ann Briggs</u>
---	---

Residence (Usual place of abode) Thornton, Idaho

If non-resident, give place and State _____

Color or race white Age at last Birthday 44 (Years)Birthplace South Cottonwood, Utah (City and State or County)Occupation Farming

If non-resident, give place and State _____

Color or race white Age at last Birthday 37 (Years)Birthplace Lynman, Thornton, Idaho (City and State or County)Occupation House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Still-born at 11 P. M.
on the date above stated.(Signature) W. L. Sutherland M.D.

(Physician or midwife)

Address Pextburg, IdahoFiled Dec 4 1930 J. R. Young

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF NEW YORK
IN SENATE
JANUARY 1, 1910
REPORT OF THE
COMMISSIONER OF THE
DEPARTMENT OF
CORRECTIONS
ON THE
ADMINISTRATION OF THE
DEPARTMENT DURING
THE YEAR 1909
ALBANY:
J. B. LIPPINCOTT
PRINTERS
1910

STATE OF NEW YORK
IN SENATE
JANUARY 1, 1910
REPORT OF THE
COMMISSIONER OF THE
DEPARTMENT OF
CORRECTIONS
ON THE
ADMINISTRATION OF THE
DEPARTMENT DURING
THE YEAR 1909
ALBANY:
J. B. LIPPINCOTT
PRINTERS
1910

1-14-31

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho

DEC 29 1930

186390

Mrs. A.E. Niederer
Thonront

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD Sarah Jane Niederer

PLACE OF BIRTH Rexburg DATE OF BIRTH Nov. 13, 1930 SEX OF CHILD Female

1. Number of children born to this mother, including present birth eight
2. Number born alive and now living seven
3. Born alive but now dead
4. Number of children stillborn one

(Please write plainly)

Information with reference to <u>FATHER</u>	Information with reference to <u>MOTHER</u>
<u>Arthur Ernest Niederer</u> (Full name)	<u>Mary Ann Briggs</u> (Full maiden name)
<u>Archer, Idaho</u> (Residence)	<u>Archer, Idaho</u> (Residence)
Age at last birthday <u>45</u>	Age at last birthday <u>37</u>
<u>South to Cottonwood Utah</u> (Birthplace)	<u>Syrian Idaho</u> (Birthplace)
<u>Farmer</u> (Occupation)	

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C. K. Macey
C.K. Macey

Special Agent, Bureau of the Census.

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
Physician should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

72763

State File No. _____

PLACE OF DEATH

County of MadisonCity of Parisburg

CERTIFICATE OF DEATH

Registration District No. 100Primary Registration District No. 2738

(No. _____)

Local Registrar's No. 62

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby. Neidier

(a) Residence. No. _____ St. _____

(Usual place of abode.)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S. if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single. Married, Widowed, or Divorced (write the word.)5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stillbirth(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9. BIRTHPLACE (city or town) Parisburg
(State or country) Idaho10. NAME OF FATHER Arthur Neidier11. BIRTHPLACE OF FATHER (city or town) South Cotton
(State or Country) wood utel12. MAIDEN NAME OF MOTHER Mary Ann Briggs13. BIRTHPLACE OF MOTHER (city or town) Archer
(State or County) Idaho

14.

Informant
(Address)

15.

Filed Dec 4, 1930

Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 14, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended decass d from

Birth, 19____, to____, 19____

that I last saw h.____ alive on____, 19____

and that death occurred, on the date stated above, at____m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:Still-birth due to
placenta-previa

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. L. Luthers, M. D.11-18, 1930 (Address) Parisburg, Idaho

19. Place of Burial, Cremation, or Removal Date of Burial

Archer Idaho Nov. 14 1930

20. Undertaker Address

Don J. Miller Parisburg

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer Farm laborer. Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid House-keepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.,** of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia, "PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

291116-040-867

PLACE OF BIRTH

RECEIVED

NOV 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S186470

County of Chesham
City of Wallace
No. _____ St. _____

CERTIFICATE OF BIRTH

Registration District No. 70 State File No. _____
(If born in hospital or institution, give name.) Prim. Registration District No. 1011 Local Registrar's No. 95

FULL NAME OF CHILD Steelborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin <u>1st</u> <u>1st</u> or other?	and	Number in order of birth <u>1st</u>	Legitimate? <u>yes</u>	Date of birth <u>March 16</u> 19 <u>30</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth. 1st (a) Born alive and now living _____

Born alive but now dead _____ Stillborn 1st

FULL NAME <u>Arthur Joseph Kramis</u>	FATHER	FULL MAIDEN NAME <u>Mary Alice Hopkins</u>	MOTHER
---------------------------------------	--------	--	--------

Residence (Usual place of abode) Wallace Residence (Usual place of abode) Wallace

It non-resident, give place and State _____ If non-resident, give place and State _____

Color or race W Age at last Birthday 35 (Years) Color or race W Age at last Birthday 29 (Years)

Birthplace Montana (City and State or County) Birthplace Indiana (City and State or County)

Occupation Forestry Occupation Mr

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 2¹⁷ P. M. on the date above stated.

(Signature) James R. Bean M.D.

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address _____

Filed Oct 29 1930 F. R. Quigley

Registrar

STATE OF NEW YORK
 COUNTY OF ALBANY
 IN SENATE
 JANUARY 1, 1911

CH. 5
 21

Residence District No. _____
 Local Residence No. _____

NAME OF CHILD

(If child is illegitimate, the words "illegitimate" or "born of" shall be inserted.)

Number _____ and in other _____ of birth _____
 Date of birth _____

What diagnosis was used to prevent Ophthalmia Neonatorum?

Contents of child of this mother, being the present birth _____

Child's name at birth _____
 Child's name at present _____
 Child's name at birth _____
 Child's name at present _____

Residence of child at birth _____

If mother has given birth to other children, give date and place of birth of each.

Date of birth _____ Place of birth _____

Residence of child at birth _____

Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____

at _____

on the date above stated.

(Signature)

Address _____

City _____

There is no attending physician or midwife after the father, householder or family nurse. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 18 1930
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70319

County of Shoshone
City of Wallace

Registration District No. 70Primary Registration District No. 1011Local Registrar's No. 27(No. Providence Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Infant of A. J. Kramis
2. FULL NAME

(a) Residence. No. 606 - Pearl St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
— — — —

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Wallace, Idaho
(State or country)

10. NAME OF FATHER A. J. Kramis

11. BIRTHPLACE OF FATHER (city or town) Hamilton Kent
(State or Country)

12. MAIDEN NAME OF MOTHER Clara Hopkins

13. BIRTHPLACE OF MOTHER (city or town) Loggott
(State or Country)

14. Informant A. J. Kramis
(Address) 606 Pearl, Wallace, Idaho

15. Filed Mar 15, 1930 F. L. Lingley
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 16, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Shelburne 1930
that I last saw him alive on 3/16/30 1930
and that death occurred, on the date stated above, at 1:10 p. m.
The CAUSE OF DEATH* was as follows:

Shelburne (died 6-8 wks)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed James R. Bean M. D.

19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Missoula, Mont. Date of Burial March 17, 1930

20. Undertaker B. L. Norstell Address Wallace

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

436-223-028851

PLACE OF BIRTH RECEIVED DEC 12 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Neuville

City of Neuville

No. 111 St.

Neuville

(If born in hospital or institution
give name.)

Registration District No. 30

State File No. 5

Prim. Registration District No. 1057

Local Registrar's No. 197

CERTIFICATE OF BIRTH **186591**

FULL NAME OF CHILD

Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>None</u>	{ and }	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>Nov. 23</u> 19 <u>30</u>
			(To be answered only in event of plural births)		(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth One (a) Born alive and now living None

Born alive but now dead None Stillborn yes one

FATHER FULL NAME <u>Elmer H. McFree</u>	MOTHER FULL MAIDEN NAME <u>Gladys M. Headley</u>
--	---

Residence (Usual place of abode) 960 6th St. 960 6th St.

It non-resident, give place and State None If non-resident, give place and State None

Color or race White Age at last Birthday 35 Color or race White Age at last Birthday 24

Birthplace Barley Mont. (City and State or County) Baker Ore. (City and State or County)

Occupation Carpenter Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 930 P. M. on the date above stated.

(Signature) John O'Leary

(Physician or midwife)

Address Care of Alvin L. L.

Filed Nov 27 1930 H. J. Sturges Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF NEW YORK
 DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS
 1883

Registration District No. 1
 City of New York
 Date of Birth 1883

(If child born in New York City, the name of the mother and the name of the father must be given.)

NAME OF CHILD
 SEX
 DATE OF BIRTH
 TIME OF BIRTH
 PLACE OF BIRTH
 NAME OF MOTHER
 NAME OF FATHER
 OCCUPATION OF FATHER
 OCCUPATION OF MOTHER
 NAME OF PHYSICIAN
 NAME OF MIDWIFE
 NAME OF NURSE
 NAME OF DOCTOR
 NAME OF CLERK
 NAME OF ATTENDING PHYSICIAN OR MIDWIFE
 NAME OF CLERK
 NAME OF ATTENDING PHYSICIAN OR MIDWIFE
 NAME OF CLERK
 NAME OF ATTENDING PHYSICIAN OR MIDWIFE

Report there was no attending physician or midwife, then the last of the child should make this report. A child is one that is not yet born, and shows other evidence of its birth.

REPORT OF THE ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of the child who was born on the 1st day of 1883 at the residence of the mother, and that the child was born alive and was born of a living mother.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72872

PLACE OF DEATH

County of Blaine

City of Camas

Registration District No. 30

Primary Registration District No. 1050

(No. Page 1 Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 161

2. FULL NAME Gladys McFee

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of =

6. DATE OF BIRTH (month, day and year) Nov 23, 1920

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Camas, Blaine (State or country) Idaho

10. NAME OF FATHER Elmer McFee

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Montana

12. MAIDEN NAME OF MOTHER Susan Heasley

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oregon

14. Informant Elmer McFee (Address) Camas, Blaine, Idaho

15. Filed Nov 29, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 23 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1930, to 1930, that I last saw him alive on 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Monstrosity.
Anencephalia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harold T. Anderson, M. D.

11-24, 1930 (Address) Camas, Blaine

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cemetery Date of Burial Nov 24 1930

20. Undertaker Name Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED DEC 13 1930
County of Latah
City of Salmon

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S186602

No. Salmon General Hospital St.

Registration District No. 41 State File No. 186602

(If born in hospital or institution
give name.)

Prim. Registration District No. 2116 Local Registrar's No. 1

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u> </u>	Twin <u> </u> Triplet <u> </u> or other? <u> </u> (To be answered only in event of plural births)	{ and { Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>Oct 27</u> 19 <u>39</u> (Month) (Day) (Year)
----------------------------	---	-------------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth One (a) Born alive and now living One

Born alive but now dead None Stillborn

FATHER	MOTHER
FULL NAME <u>Dorvan Beckman</u>	FULL MAIDEN NAME <u>Margaret Steele</u>
Residence (Usual place of abode) <u>Idaho Creek</u>	Residence (Usual place of abode) <u>Idaho Creek</u>
If non-resident, give place and State <u> </u>	If non-resident, give place and State <u> </u>
Color or race <u>Wh</u> Age at last Birthday <u>31</u> (Years)	Color or race <u>Wh</u> Age at last Birthday <u>22</u> (Years)
Birthplace <u>Mont</u> (City and State or County)	Birthplace <u>Wyoming</u> (City and State or County)
Occupation <u>Ranch</u>	Occupation <u>Ranch</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 9 P M.
on the date above stated. (Signature) F. S. Wright M.D.

(Physician or midwife)

Address Salmon

Filed 12/10 1939 Chas. Bellamy
Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

A—In 1900, the first year of the century, the population of the United States was 76,000,000. In 1910 it was 92,000,000. In 1920 it was 106,000,000. In 1930 it was 122,000,000. In 1940 it was 137,000,000. In 1950 it was 152,000,000. In 1960 it was 178,000,000. In 1970 it was 203,000,000. In 1980 it was 226,000,000. In 1990 it was 250,000,000. In 2000 it was 281,000,000. In 2010 it was 312,000,000. In 2020 it was 333,000,000. In 2030 it was 354,000,000. In 2040 it was 375,000,000. In 2050 it was 396,000,000. In 2060 it was 417,000,000. In 2070 it was 438,000,000. In 2080 it was 459,000,000. In 2090 it was 480,000,000. In 2100 it was 501,000,000.

(P) 000000000000

TESTIMONY OF ATTENDING PHYSICIAN OR MIDWIFE.

RECEIVED

(47887)

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

fish-own

2000

CONFIDENTIAL

Advised to be by persons or class brought up (1)

(11) "Billboard" for name of subject

100-443887-100

141

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH DEC 13 1936

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 186605

County of Twin Falls

City of Twin Falls

No. _____ St.

T. F. and J. Young

(If born in hospital or institution
give name.)

Registration District No. 37 State File No. 186605

Prim. Registration District No. 2085 Local Registrar's No. 5-22

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and } Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Nov 26</u> 19 <u>36</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 16 (a) Born alive and now living 12

Born alive but now dead 2 Stillborn 3

FATHER

FULL NAME Frank Weighall

Residence (Usual place of abode) Hansen

If nonresident, give place and State B2 Idaho

Color or race W Age at last Birthday 49 (Years)

Birthplace Cabley Idaho

(City and State or Country)

Occupation Laborer

MOTHER

FULL MAIDEN NAME Agatha Wells

Residence (Usual place of abode) Hansen

If nonresident, give place and State B2 Idaho

Color or race W Age at last Birthday 46 (Years)

Birthplace Wash

(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 620 W. M.
on the date above stated.

(Signature) B. D. Weaver

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address _____

Filed 2

MAY 10 1979



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of birth stated.

PLACE OF BIRTH

County of Adair
City of Boise
No. 1617 N. 24 St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

186675

CERTIFICATE OF BIRTH

JAN 10 1931

S

The Salvation Army
(If born in hospital or institution
give name.)

Registration District No. 3 State File No. _____Prim. Registration District No. 1004 Local Registrar's No. 603

FULL NAME OF CHILD _____

Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin <u>Triplet</u> { and { Number in order of birth <u>2</u>	Legitimate? <u>yes</u>	Date of birth <u>Dec. 17</u> 19 <u>30</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What prophylactic was used to prevent Ophthalmia Neonatorum? KNumber of child of this mother, including present birth 3 (a) Born alive and now living 2Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME <u>John Joseph Lipscomb</u>	FULL MAIDEN NAME <u>Laabel Bremner</u>
Residence (Usual place of abode) <u>1115 O'Farrel</u>	Residence (Usual place of abode) <u>1115 O'Farrel</u>
If non-resident, give place and State <u>Boise, Ida.</u>	If non-resident, give place and State <u>Boise, Idaho</u>
Color or race <u>white</u> Age at last Birthday <u>29</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>22</u> (Years)
Birthplace <u>Tennessee</u> (City and State or County)	Birthplace <u>Keith, Scotland</u> (City and State or County)
Occupation <u>Cook</u>	Occupation <u>Stenographer</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 10:05 A. M.
on the date above stated.

(Signature) Sutomey

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address _____

Filed 2-29 1930 W.H. Rhodes
Registrar.

100-443887-100

1. The first part of the document is a header section containing the following information:

- 1.1. The name of the organization: "The National Security Council" (NSC).
- 1.2. The name of the document: "The National Security Council Directive" (NSC-D).
- 1.3. The name of the subject: "The National Security Council Directive" (NSC-D).

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
Physician should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No.

72967 ✓

PLACE OF DEATH

County of Ada
City of Boise.

CERTIFICATE OF DEATH

Registration District No. 3Primary Registration District No. 1004(No. Salvation Army Rescue Home.)Local Registrar's No. 334

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Lipscomb.(a) Residence. No. St.

(Usual place of abode.)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

(If nonresident give city or town and State.)
How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male.

4. COLOR OR RACE

White.5. Single. Married. Widowed,
or Divorced (write the word.)Single.

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) December 17th 1930

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or
min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of workNone.(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Idaho.
(State or country)

10. NAME OF FATHER

John J. Lipscomb.11. BIRTHPLACE OF FATHER (city or town)
(State or Country)Tenn.

12. MAIDEN NAME OF MOTHER

Isabel Bremner.13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)Scotland.

14.

Informant
(Address)John J. Lipscomb.Boise, Idaho.

15.

Filed 12-19-30W. H. P. Rader
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 17th 1930

(Month)

(Day)

19.
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 17, 1930, to Dec 17, 1930that I last saw him alive on not alive, 1930and that death occurred, on the date stated above, at 6 m.*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:Steel horn (twin)(duration) yrs. mos. ds.
CONTRIBUTORY Twisted umbilical
(Secondary) Ards

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death? ✓Did an operation precede death? ✓ Date ofWas there an autopsy? ✓What test confirmed diagnosis? Autopsy(Signed) Autopsy, M. D.
12/19/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal

County Cemetery.

Date of Burial

12/19/30 19

20. Undertaker

Wm. McBratney.

Address

Boise, Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of** (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of Bear Lake
City of Raymond
No. 186793 STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF RECEIVED JAN 8 1930
Registration District No. 55 State File No. 186793
Prim. Registration District No. 230 Local Registrar's No. 230

FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female Twin Triplet or other? no and no Number in order of birth 1 Legitimate? yes Date of birth 8 12 1930
(To be answered only in event of plural births) (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? no

Number of child of this mother, including present birth 2 (a) Born alive and now living 0
Born alive but now dead 1 Stillborn 1

FATHER		MOTHER	
FULL NAME	<u>John Elmer Reeves</u>	FULL MAIDEN NAME	<u>Mabel Leischer</u>
Residence (Usual place of abode)	<u>Raymond</u>	Residence (Usual place of abode)	<u>Raymond</u>
If nonresident, give place and State		If nonresident, give place and State	
Color or race	<u>white</u>	Color or race	<u>white</u>
Age at last Birthday	<u>35</u>	Age at last Birthday	<u>20</u>
	(Years)		(Years)
Birthplace	<u>Wyo.</u>	Birthplace	<u>Ida</u>
	(City and State or Country)		(City and State or Country)
Occupation	<u>farmer</u>	Occupation	<u>housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 1.309 M.
on the date above stated. Stillborn

(Signature) J. P. Galster
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Montpelier Ida
Filed 12/31/1930 HHK
Registrar.

THE FOLLOWING INFORMATION WAS OBTAINED FROM THE RECORDS OF THE BUREAU OF PRISONS AND REFORMATORY INSTITUTIONS OF THE STATE OF CALIFORNIA:

STATE OF CALIFORNIA

County of _____
Date of birth _____
Place of birth _____

It being the policy of the Department of Corrections to maintain accurate records of all persons in its custody, the following information is being furnished to you:

NAME OF PRISONER

First Name _____
Last Name _____
Middle Name _____
Date of Birth _____
Place of Birth _____

It is requested that you advise the Department of Corrections of any change in the above information.

Very truly yours,
Director of Corrections

It is requested that you advise the Department of Corrections of any change in the above information.

Very truly yours,
Director of Corrections

It is requested that you advise the Department of Corrections of any change in the above information.

Very truly yours,
Director of Corrections

It is requested that you advise the Department of Corrections of any change in the above information.

Very truly yours,
Director of Corrections

It is requested that you advise the Department of Corrections of any change in the above information.

DEPARTMENT OF CORRECTIONS
RECORDS SECTION
STATE OF CALIFORNIA

Registration Number _____
Date of Birth _____
Place of Birth _____

It is requested that you advise the Department of Corrections of any change in the above information.

Very truly yours,
Director of Corrections

It is requested that you advise the Department of Corrections of any change in the above information.

Very truly yours,
Director of Corrections

It is requested that you advise the Department of Corrections of any change in the above information.

Very truly yours,
Director of Corrections

It is requested that you advise the Department of Corrections of any change in the above information.

Very truly yours,
Director of Corrections

It is requested that you advise the Department of Corrections of any change in the above information.

Very truly yours,
Director of Corrections

It is requested that you advise the Department of Corrections of any change in the above information.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **73005**

PLACE OF DEATH
County of **Peas Lake**
City of **Raymond**

Registration District No. **32**
Primary Registration District No. **236**

Local Registrar's No. _____

2. FULL NAME

Stillborn infant Reeves
(If death occurred in a hospital or institution, give its name instead of street and number.) **206**
Raymond Ida St. **JAN 8 1930**

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Female** 4 COLOR OR RACE **white** 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) **8-12-30**

7 AGE **Stillborn** 1 day, _____ hrs. or _____ min. If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) **Raymond**
(State or country)

10 NAME OF FATHER **John Elmer Reeves**

11 BIRTHPLACE OF FATHER (city or town) **Alma wyo.**
(State or country)

12 MAIDEN NAME OF MOTHER **Maabel Plusghes**

13 BIRTHPLACE OF MOTHER (city or town) **Raymond**
(State or country)

14 Informant **J. P. Gaultier**
(Address) **Montpelier**

15 Filed **12/31/1930**

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **8** **12** **30**
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from **8/12/30** to **8/12/30**

that I last saw **her** alive on _____ 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows: **Stillborn**

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? **J. P. Gaultier**
(Signed) **8-12-30** (Address) **Montpelier**

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal **Raymond** Date of Burial **8/12/1930**

20 Undertaker **Montpelier** Address **Raymond**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JAN 5 1931

STATE OF IDAHO

S

County of Bingham

DEPARTMENT OF PUBLIC WELFARE

City of Basalt

BUREAU OF VITAL STATISTICS

No. _____ St. _____

CERTIFICATE OF BIRTH

186830

Registration District No. 121 State File No. _____

(If born in hospital or institution
give name.)

Prim. Registration District No. 2194 Local Registrar's No. 399

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u>1</u>	and {	Number in order of birth <u>1st</u>	Legiti- mate? <u>yes</u>	Date of birth <u>Dec 22</u> 19 <u>30</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? no

Number of child of this mother, including present birth 4 (a) Born alive and now living 5

Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME Ellis Armstrong

MOTHER
FULL MAIDEN NAME Winona Marie Kindell

Residence (Usual place of abode) Basalt

Residence (Usual place of abode) Basalt

If nonresident, give place and State _____

If nonresident, give place and State _____

Color or race white Age at last Birthday 36

Color or race white Age at last Birthday 35

Birthplace Utah (Years)

Birthplace Utah (Years)

(City and State or Country)

(City and State or Country)

Occupation farmer

Occupation housekeeper

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 10:45 9 M.
on the date above stated.

(Signature) H. E. Gurett

(Physician or midwife)

Address Chelley, Idaho

Filed Jan 1 1931 M. H. Matus & Co.

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 13035

PLACE OF DEATH
County of Bingham
City of Basalt

Registration District No. 121
Primary Registration District No. 2192

Local Registrar's No. 187

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillbirth Baby, Armstrong
(a) Residence. No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. none yrs. none mos. none ds. How long in U. S., if of foreign birth? yrs. mos. ds.

206

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____
6. DATE OF BIRTH (month, day and year) _____
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0 0 0
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer none

9. BIRTHPLACE (city or town) Basalt, Ida
(State or country)

10. NAME OF FATHER Ellis Armstrong
11. BIRTHPLACE OF FATHER (city or town) Utah
(State or Country)
12. M maiden NAME OF MOTHER Almona Maude Kendall
13. BIRTHPLACE OF MOTHER (city or town) Utah
(State or Country)

14. Informant Elas armstrong
(Address) Basalt, Idaho

15. Filed Dec 23, 1930 Wm M. E. Tamm
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22, 1930, to Dec 22, 1930
that I last saw h im alive on head, 19____
and that death occurred, on the date stated above, at 10:45 P. m.
The CAUSE OF DEATH* was as follows:

Stillbirth

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY none
(Secondary)
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted at place of death
if not at place of death? _____
Did an operation precede death? no Date of _____
Was there an autopsy? no

What test confirmed diagnosis Physical Signs
(Signed) H. E. G. G. G. M. D.
12/23, 1930 (Address) Shelley, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Firth Cemetery
Date of Burial Dec 23 1930

20. Undertaker Ellis Armstrong
Address Basalt, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH		RECEIVED JAN 2 1931		STATE OF IDAHO	
County of <u>Bonneville</u>		DEPARTMENT OF PUBLIC WELFARE			
City of <u>Idaho Falls Idaho</u>		BUREAU OF VITAL STATISTICS			
No. _____ St. _____				CERTIFICATE OF BIRTH	
P. O. <u>2 Hospital</u>		Registration District No. <u>73</u>		State File No. <u>186888</u>	
(If born in hospital or institution give name.)		Prim. Registration District No. <u>21.12</u>		Local Registrar's No. <u>546</u>	
FULL NAME OF CHILD <u>Stillborn</u>		Prestwich			
(If stillborn, substitute the word "Stillbirth" for name of child)					
Sex of Child <u>male</u>	Twin <u>Triplet</u> or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>11 - 26</u> 19 <u>30</u>	(Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? <u>none</u>					
Number <u>1</u> child of this mother, including present birth. (a) Born alive and now living <u>6</u>					
Born alive but now dead <u>1</u> Stillborn <u>3</u>					
FATHER			MOTHER		
FULL NAME <u>George M. Prestwich</u>			FULL MAIDEN NAME <u>Ruth Munsee</u>		
Residence (Usual place of abode) <u>Route 4 Idaho Falls</u>			Residence (Usual place of abode) <u>same</u>		
It non-resident, give place and State _____			If non-resident, give place and State _____		
Color or race <u>White</u> Age at last Birthday <u>50</u> (Years)			Color or race <u>White</u> Age at last Birthday <u>39</u> (Years)		
Birthplace <u>Merion, Utah</u> (City and State or County)			Birthplace <u>Idaho Falls</u> (City and State or County)		
Occupation <u>Farmer</u>			Occupation <u>Idaho Falls</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 10 47 P. M. on the date above stated.

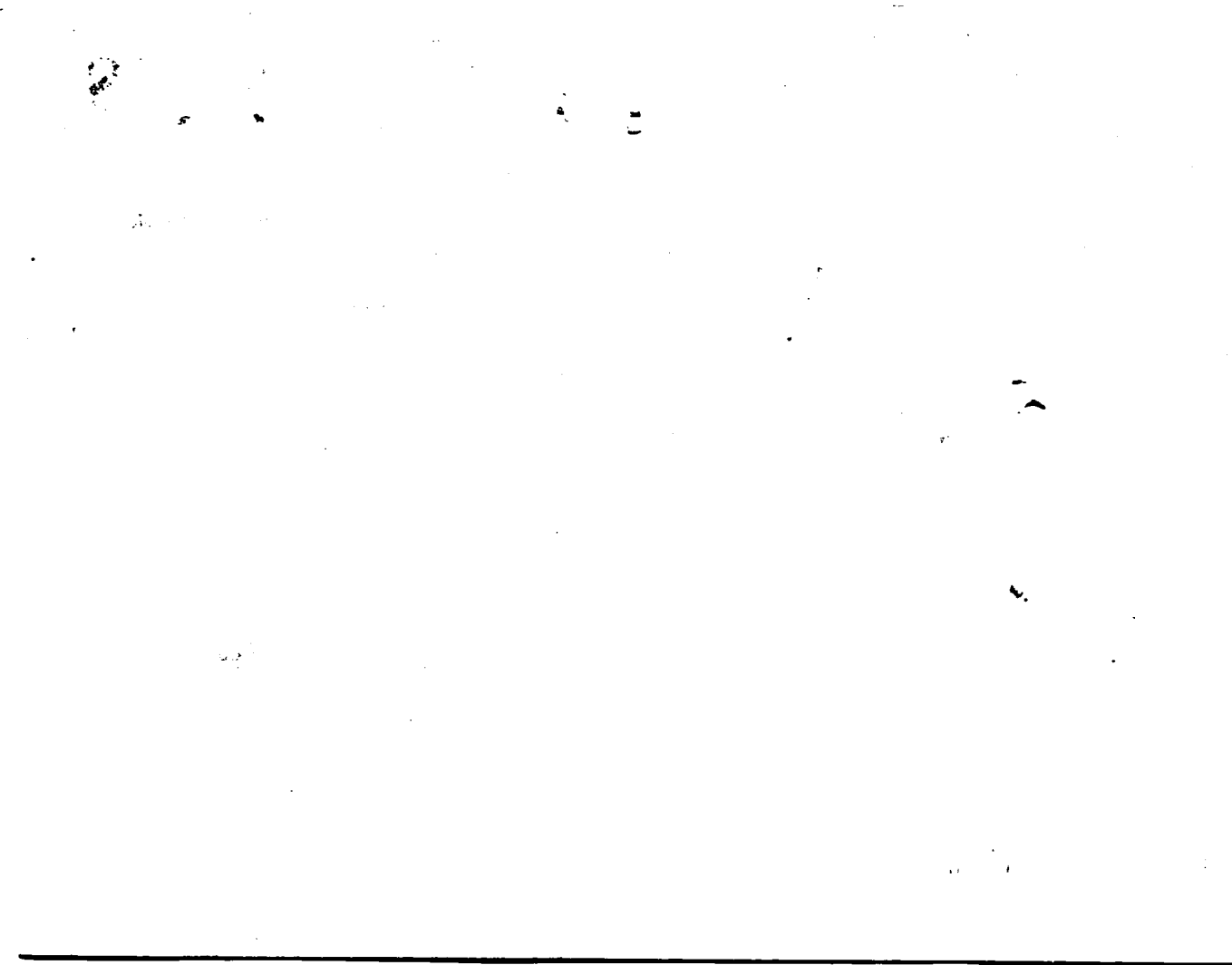
(Signature) John O. Miller M.D. (Physician or Midwife)

Address Idaho Falls, Idaho

Filed 12/13 1930 Certification

Registration

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

PHYSICIAN

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 2 1931

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 73082

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

CERTIFICATE OF DEATH

Registration District No. 73
Primary Registration District No. 2140
(No.)

Local Registrar's No. 231

(If death occurred in a hospital or institution, give its name instead of street and number)

2. FULL NAME Baby Prestwich

206

(a) Residence. No.

St.

(Usual place of abode.)

(If nonresident give city or town and State.)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 26, 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls, Bonneville Co.
(State or country) Idaho

10. NAME OF FATHER

George M. Prestwich

11. BIRTHPLACE OF FATHER (city or town) Maroni, Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Ruth Munsee

13. BIRTHPLACE OF MOTHER (city or town) Ogden, Utah
(State or Country)

14. Informant (Address) C. Miller M.D. Idaho Falls

15. Filed Dec 2, 1930 Registrar. C. M. M.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

11 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw h. alive on 19
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Stillborn - Monstrosity - Cause unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John O'Mellar M. D.
Dec 1, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal

Date of Burial

Idaho Falls etc

26 1930

20. Undertaker

Address

none

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Saleman, (b) Grocery;** (a) **Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications. as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.,** of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia, "PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED JAN 3 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S
187155

County of Caribou
City of Soda Springs
No. _____ St. _____

CERTIFICATE OF BIRTH

Registration District No. 82 State File No. _____
(If born in hospital or institution give name.) Prim. Registration District No. 2157 Local Registrar's No. 39

FULL NAME OF CHILD Stallborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>—</u>	and	Number in order of birth <u>—</u>	Legiti- mate? <u>yes</u>	Date of birth <u>Nov. 22 1930</u>
(To be answered only in event of plural births)				(Month)	(Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 7 (a) Born alive and now living 7

Born alive but now dead 1 Stillborn 1

FATHER FULL NAME <u>Kenneth L. Ball</u>	MOTHER FULL MAIDEN NAME <u>Zina Horsley</u>
--	--

Residence (Usual place of abode) Soda Springs

If non-resident, give place and State —

Color or race White Age at last Birthday 38 (Years)

Birthplace Alexander, Ida (City and State or County)

Occupation Farmer + Bishop

Residence (Usual place of abode) Soda Springs

If non-resident, give place and State —

Color or race White Age at last Birthday 40 (Years)

Birthplace Soda Springs, Ida (City and State or County)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was From above Stillborn at 7:40 A. M. on the date above stated.

(Signature) Russell Ficht

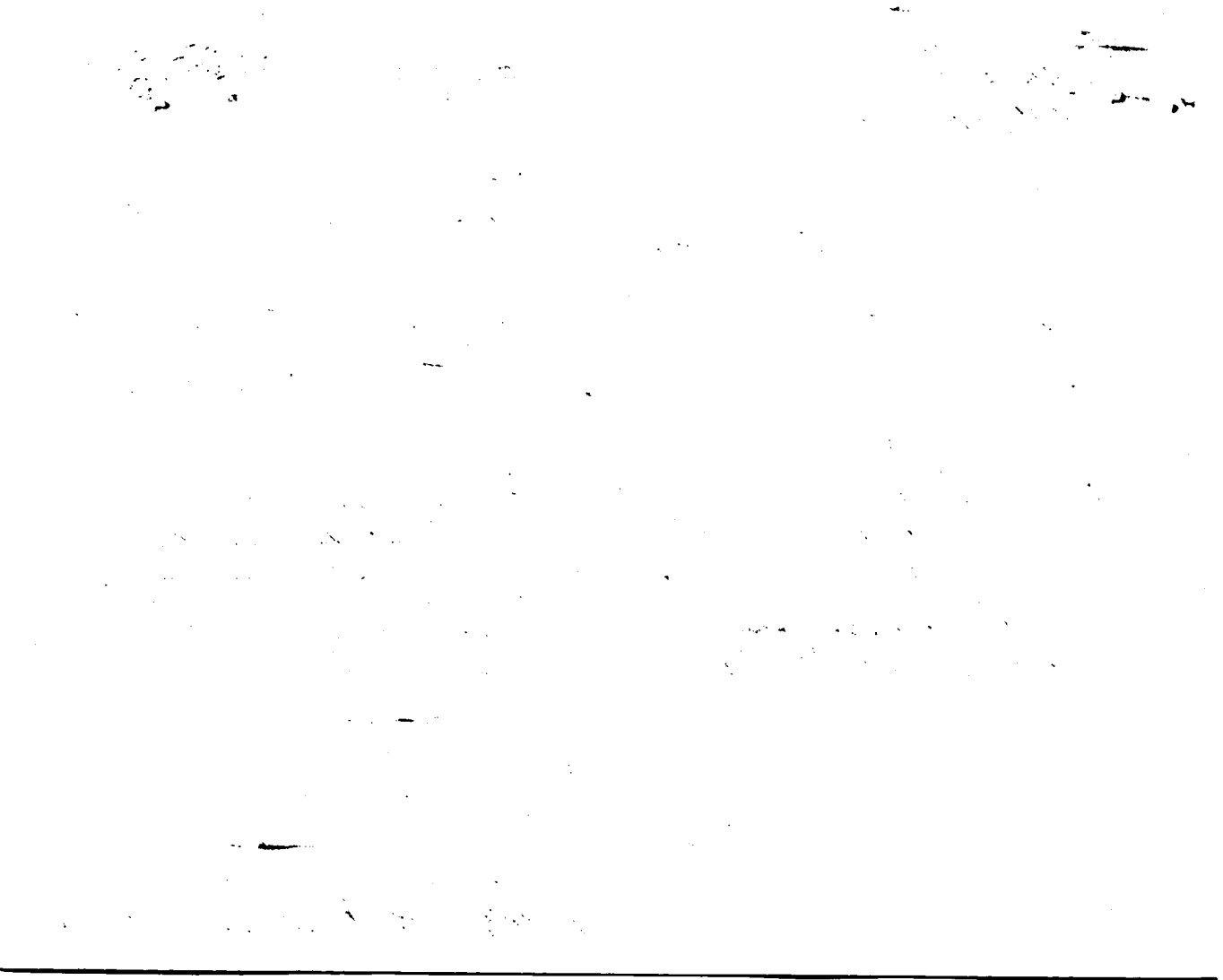
(Physician or midwife)

Address Soda Springs, Ida

Filed 11/30 19 30 Dr. Russell Ficht
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

for each and the number of each, in order of birth stated.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 1310

PLACE OF DEATH

County of Gambier
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159

Local Registrar's No. 31

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Balls

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 11-22-30

7. AGE Years Months Days If LESS than 1 day, hrs. or min. Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Soda Springs (State or country)

10. NAME OF FATHER Kenneth Balls

11. BIRTHPLACE OF FATHER (city or town) Soda Springs (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Zina Forsberg

13. BIRTHPLACE OF MOTHER (city or town) Soda Springs (State or Country)

14. Informant X Kenneth G. Balls (Address) Soda Springs Ida

15. Filled 11-22-30 D. Russell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1930, to at birth that I last saw him alive on Nov. 27, 1930, and that death occurred, on the date stated above, at at birth.

The CAUSE OF DEATH* was as follows:

Stillborn - may probably
trauma to mother who accidently
fell down basement
steps (duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary) (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Same

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Russell Sigist M. D. Nov 22, 1930 (Address) Soda Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Soda Springs Ida Date of Burial 11-22-30

20. Undertaker St. Anthony Address Soda Springs

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH **S** 187162

County of Idaho
City of _____
No. _____ St. _____

(If born in hospital or institution
give name.)

Registration District No. _____ State File No. _____

Prim. Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Boy</u>	Twin <u>✓</u> Triplet or other?	Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>Nov 3</u> 19 <u>30</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Silver Nitrate 2%

Number of child of this mother, including present birth one (a) Born alive and now living one

Born alive but now dead _____ Stillborn _____

FULL NAME <u>Joseph L. Ray Squires</u>	FATHER	FULL MAIDEN NAME <u>Virginia Anderson</u>	MOTHER
--	--------	---	--------

Residence (Usual place of abode) <u>Mustang</u>	Residence (Usual place of abode) <u>Mustang</u>
---	---

If non-resident, give place and State _____

Color or race <u>White</u>	Age at last Birthday <u>28</u> (Years)	Color or race <u>White</u>	Age at last Birthday <u>18</u> (Years)
----------------------------	--	----------------------------	--

Birthplace <u>Utah</u>	City and State or County	Birthplace <u>Idaho</u>	City and State or County
------------------------	--------------------------	-------------------------	--------------------------

Occupation <u>Rubber</u>	Occupation <u>Housewife</u>
--------------------------	-----------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 6:30 A.M. on the date above stated.

(Signature) Hugh E. Dean

(Physician or midwife)

Address Burley, Ida.

Filed 1-2-1931

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
Exact statement of OCCUPATION is very important. See instructions on back.

PHYSICIAN

✓ REC'D DEC 23 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 73194

PLACE OF DEATH
Cassia

CERTIFICATE OF DEATH

County of _____
City of Burley

Registration District No. _____

Primary Registration District No. _____

(No. _____)

Local Registrar's No. _____

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Squires

(a) Residence. No. _____ St. _____

(Usual place of abode.)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

(If nonresident give city or town and State.)
How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
M4. COLOR OR RACE
W5. Single, Married, Widowed,
or Divorced (write the word.)
Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 3 1930

7. AGE Years Months Days If LESS than 1 day,
STILL BORN hrs. or
min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Burley
(State or country) Idaho.10. NAME OF FATHER
Roy Squires11. BIRTHPLACE OF FATHER (city or town) Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Virginia Anderson

13. BIRTHPLACE OF MOTHER (city or town) Idaho.
(State or Country)14. Informant Mrs. Virginia Squires
(Address) Murtaugh Ida

15. Filed 12/11/30 1930

Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 3 1930

(Month)

(Day)

19

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 3 - 1930, to Nov 3, 1930

that I last saw him alive on Nov 3, 1930

and that death occurred, on the date stated above, at 7.30 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Infectious Mononucleosis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemist

(Signed) M. D.

Nov 3, 1930 (Address) Burley

19. Place of Burial, Cremation, or Removal

Burley Ida

Date of Burial

Nov. 5-30

20. Undertaker

D.E. Johnson

Address

Burley Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Saleman, (b) Grocery;** (a) **Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same ac-

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of** (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH **S** 187163

County of 16
City of
No. St.

Registration District No. State File No.
Prim. Registration District No. Local Registrar's No.

(If born in hospital or institution give name.)

FULL NAME OF CHILD Lucy (If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Boy</u>	Twin <u>2</u> Triplet or other? <u>and</u> Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>Nov 3</u> 19 <u>30</u> (Month) (Day) (Year)
-------------------------	---	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? Silver nitrate 290

Number of child of this mother, including present birth one (a) Born alive and now living one
Born alive but now dead Stillborn

FATHER	MOTHER
FULL NAME <u>Joseph L. Roy Squires</u>	FULL MAIDEN NAME <u>Virginia Anderson</u>
Residence (Usual place of abode) <u>Muntalgh</u>	Residence (Usual place of abode) <u>Muntalgh</u>
If non-resident, give place and State	If non-resident, give place and State
Color or race <u>White</u> Age at last Birthday <u>28</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>18</u> (Years)
Birthplace <u>Utah</u> (City and State or County)	Birthplace <u>Idaho</u> (City and State or County)
Occupation <u>Farmer</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 6:40 A.M. on the date above stated.

(Signature) Hugh E. Dean
M.D.
(Physician or midwife)

Address Burley, Ida.

Filed 1-2-1931 J. K. Carter
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED JAN 7 1931
County of Blaine
City of Burley
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

187168

Registration District No. 19 State File No. _____
(If born in hospital or institution give name.)
Prim. Registration District No. 2015 Local Registrar's No. _____
FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and {	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Nov 20 1930</u> (Month) (Day) (Year)
----------------------------	------------------------------	-------	--------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? new Silver 1940

Number of child of this mother, including present birth 5 (a) Born alive and now living 4

Born alive but now dead _____ Stillborn 1

FATHER FULL NAME <u>Archie McLean</u>	MOTHER FULL MAIDEN NAME <u>Margaret Lee</u>
--	--

Residence (Usual place of abode) <u>Burley</u>	Residence (Usual place of abode) <u>Burley</u>
--	--

If non-resident, give place and State _____	If non-resident, give place and State _____
---	---

Color or race <u>White</u> Age at last Birthday <u>50</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>38</u> (Years)
---	---

Birthplace <u>Ontario Canada</u> (City and State or County)	Birthplace <u>Lyonsville Iowa</u> (City and State or County)
---	--

Occupation <u>Patrolman</u>	Occupation <u>Housewife</u>
-----------------------------	-----------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn ^{Born alive} at 9:50 P. M. on the date above stated.

(Signature) E. H. Elmore

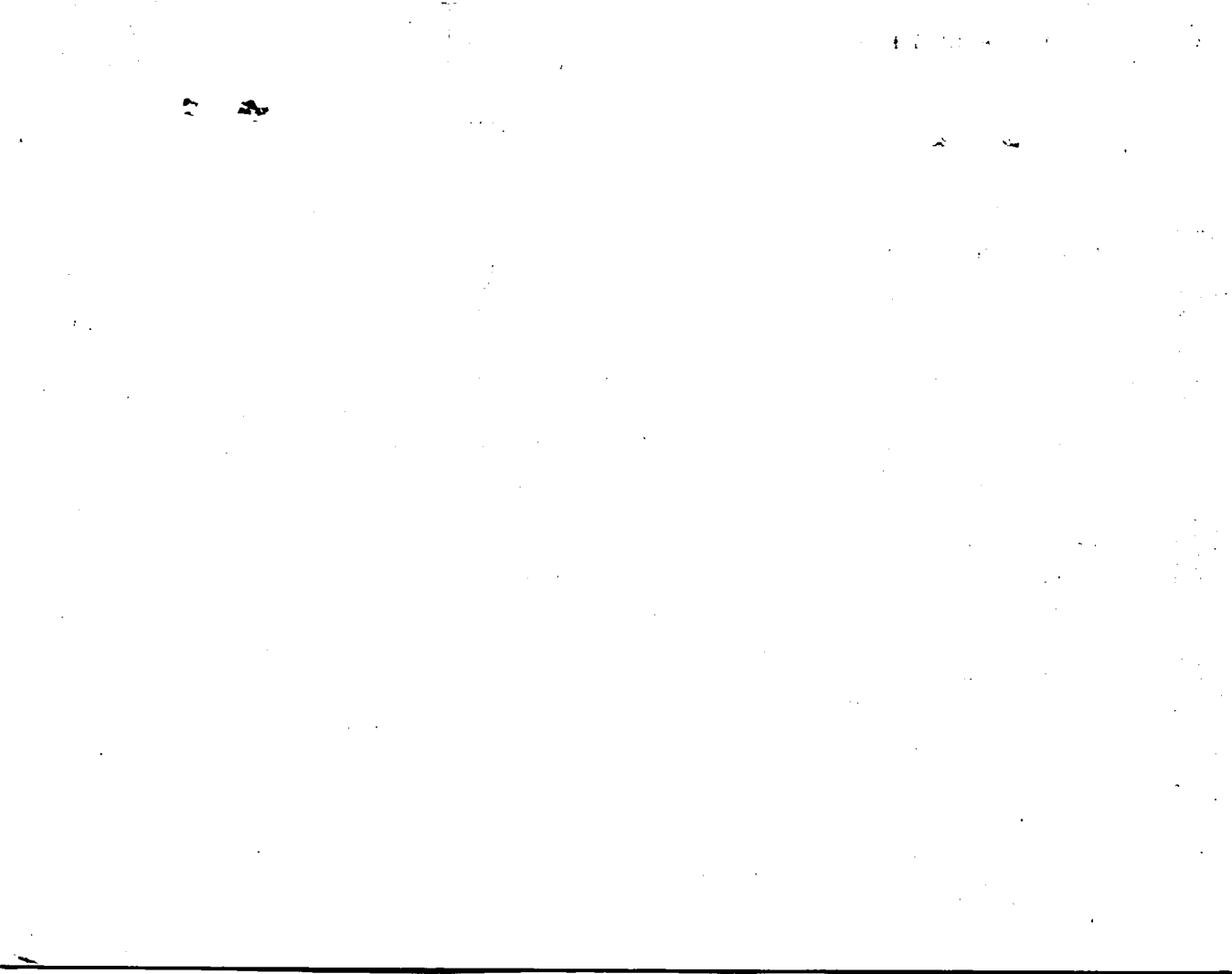
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Reister

Filed Dec 9 1930

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. NO. 100-101-102

RECEIVED JAN 7 1931

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Cassia
City of Burley

Registration District No.

Primary Registration District No.

(No. St.)

State File No. 73201

Local Registrar's No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Steebarn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemale - White

(Write the word)

6. DATE OF BIRTH

Nov 20 1930
(Month) (Day) (Year)

7. AGE

IF LESS than 1
day how many
hrs. or
min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Burley Idaho10. NAME OF
FatherArchie McLean11. BIRTHPLACE
OF FATHER

(State or Country)

Ontario Canada12. MAIDEN NAME
OF MOTHERMargaret Lee13. BIRTHPLACE
OF MOTHER

(State or Country)

Grinnell, Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Archie McLean

(Address)

Burley

15.

Filed 7-2-31

1931

F. H. Custer
Local RegistrarMEDICAL CERTIFICATE OF DEATH 206

16. DATE OF DEATH

Nov 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn full term
Hydrocephalus +
Spiral Rickets
(Duration) yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. H. Blum M. D.12-10-1930(Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE FULLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED DEC 28 1930

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

187180

County of.....
City of.....
No. 493 213.016 319 St.

(If born in hospital or institution
give name.)

Registration District No..... State File No.....
Prim. Registration District No..... Local Registrar's No.....

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Girl</u>	Twin Triplet or other? (To be answered only in event of plural births)	{ and }	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Nov 13</u> (Month) (Day) (Year) <u>19 30</u>
--------------------------	---	---------	--------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth. Three (a) Born alive and now living two
Born alive but now dead 0 Stillborn one

FATHER FULL NAME <u>George I. Mitchell</u> Residence (Usual place of abode) <u>Burley</u> If non-resident, give place and State..... Color or race <u>white</u> Age at last Birthday <u>32</u> Birthplace <u>Idaho</u> Occupation <u>Farming</u>	MOTHER FULL MAIDEN NAME <u>Myrtle Carson</u> Residence (Usual place of abode) <u>Burley</u> If non-resident, give place and State..... Color or race <u>white</u> Age at last Birthday <u>31</u> Birthplace <u>Idaho</u> Occupation <u>Housewife</u>
--	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 11:53 P.M.
on the date above stated.

(Signature) Hugh C. Dean
M.D.
(Physician or midwife)

Address Burley
Filed 12-12-19 30 J. H. Carter
Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. _____
Local Registration No. _____

FULL NAME OF CHILD

Sex of child (M or F) _____
Date of birth (Month, Day, Year) _____
Place of birth (City and State or Country) _____
If born abroad, give place and date _____

What prophylactic was used to prevent syphilis? _____

Number of child of this mother, including present birth _____

FATHER'S NAME _____
MOTHER'S NAME _____

Place of birth (City and State or Country) _____
If born abroad, give place and date _____
Color of eyes _____
Color of hair _____
Height _____
Weight _____
Occupation _____
Education _____
Religion _____
Date of birth (Month, Day, Year) _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
on the date above stated.

When there was no attending physician or midwife, then the father, householder, or other person should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Signature of Physician or Midwife _____
Address _____

MARGIN RESERVED FOR BINDING

187180 +

PHYSICIAN

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

DEC 28 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73105

PLACE OF DEATH
County of Cassia
City of Burley
Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Mitchell
(a) Residence. No. St.
(Usual place of abode.)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE White	5. Single, Married, Widowed, or Divorced (write the word.) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year) Nov. 14 1930		
7. AGE Still Born	Years Months Days	If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (city or town) Burley, Ida.
(State or country)

PARENTS

10. NAME OF FATHER Geo. T. Mitchell
11. BIRTHPLACE OF FATHER (city or town) Shelling, Ida. (State or Country)
12. MAIDEN NAME OF MOTHER Myrtle Carson
13. BIRTHPLACE OF MOTHER (city or town) Oakley, Ida. (State or Country)

14. Informant Geo. T Mitchell
(Address) Burley Ida
15. Filed 12-10-30, 1930
F. H. Carter
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. 14, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Nov. 14, 1930, to Nov. 14, 1930
that I last saw her alive on Nov 14, 1930
and that death occurred, on the date stated above, at 11:00 a.m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H. E. Johnson M. D.
Nov 15, 1930 (Address) Burley, Ida.

19. Place of Burial, Cremation, or Removal Burley Ida
Date of Burial Nov. 14 1930

20. Undertaker D. E. Johnson Burley Ida
Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of (name origin);** "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

168-113-218-493
PLACE OF BIRTH Idaho JAN 7 1931
County of Clearwater
City of Aksakka
No. St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S
187215

Registration District No. 90 State File No.

(If born in hospital or institution
give name.)

Prim. Registration District No. 2187 Local Registrar's No. 107

FULL NAME OF CHILD

Arthur Joy

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child

M

Twin
Triplet
or other?
(To be answered only in event of plural births)

and {
Number
in order
of birth

Legiti-
mate?

Yes

Date of
birth

12
(Month)

13
(Day)

1930
(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 1

Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME Levi Joy

Residence (Usual place of abode) Aksakka

If nonresident, give place and State

Color or race Indian Age at last Birthday 47

Birthplace Idaho (City and State or Country)

Occupation Laborer

MOTHER
FULL MAIDEN NAME Edna Miller

Residence (Usual place of abode) Aksakka

If nonresident, give place and State

Color or race Indian Age at last Birthday 26

Birthplace Idaho (City and State or Country)

Occupation

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 11:15 M.
on the date above stated.

(Signature) Mrs. Adams, Mother of Day

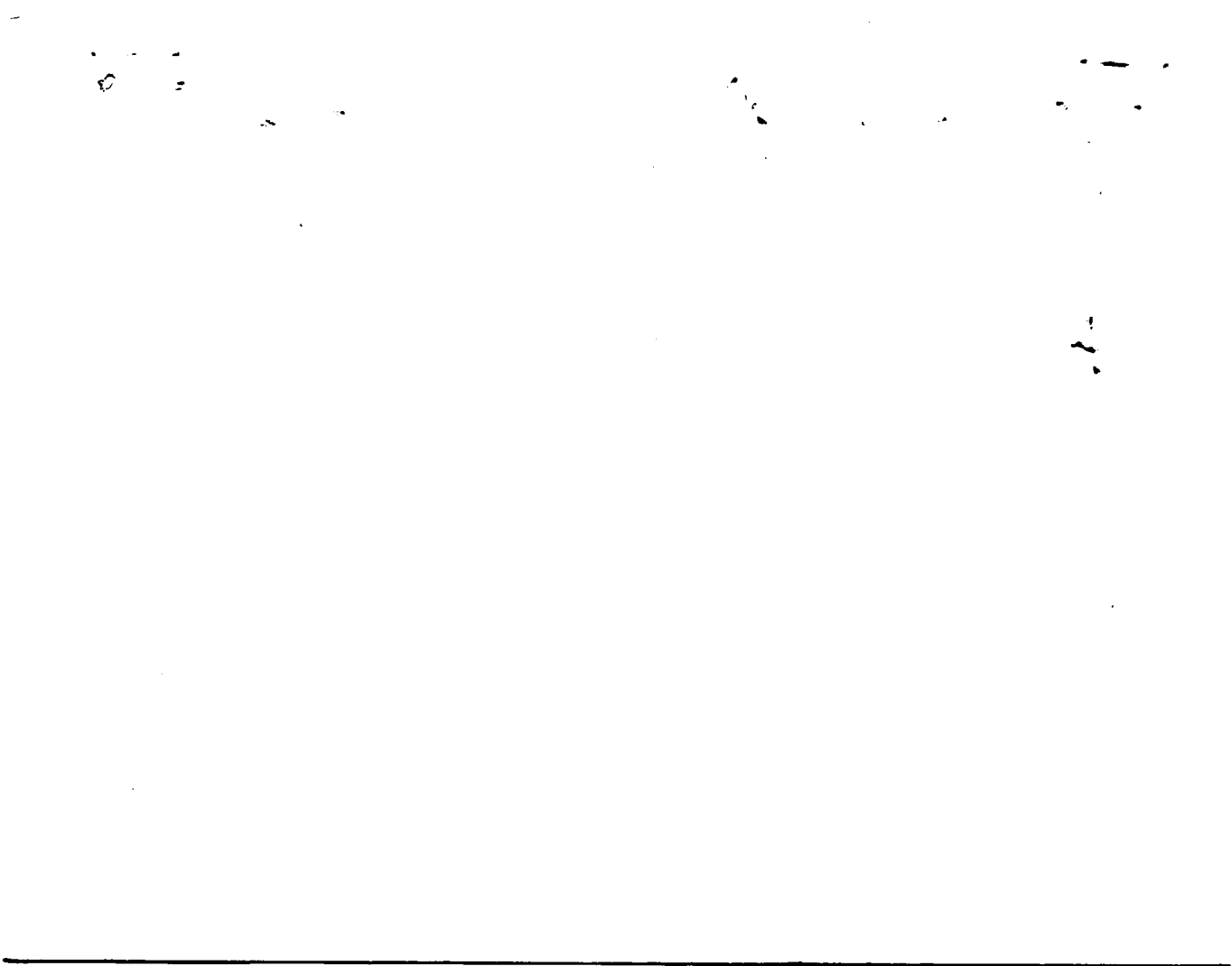
(Physician or midwife)

Address Aksakka Idaho

Filed 12/13 19 1930

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73212

PLACE OF DEATH
County of Clearwater
City of Ahsakha

Registration District No. 70
Primary Registration District No. 2187

Local Registrar's No. 89

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby not named

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX male 4. COLOR OR RACE Indian 5. Single, Married, Widowed, or Divorced (write the word)
5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of
6. DATE OF BIRTH (month, day and year) Dec 13 - 1930
7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Ahsakha Ida
(State or country)

10. NAME OF FATHER Scott Fry

11. BIRTHPLACE OF FATHER (city or town) Ida
(State or Country)

12. MAIDEN NAME OF MOTHER Edna Miller

13. BIRTHPLACE OF MOTHER (city or town) Ida
(State or Country)

14. Informant Mrs Adams
(Address) Ahsakha

15. Filed 12/13, 19 1930
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 13 19 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred, on the date stated above, at 11:2 m.
The CAUSE OF DEATH* was as follows:

Borned Dead
Had no signs
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?
Did an operation precede death? Date of.....
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W.A. Shaw Coroner M.D.
12/13, 19 1930 (Address) Orfino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Ahsakha Ida Date of Burial Dec 14 19 1930

20. Undertaker W.A. Shaw Address Orfino

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

LEWIS WILLIAMS
SPECIAL AGENT

187215

Boise, Idaho.

JAN 28 1931

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND OBTAIN THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due time.

FULL NAME OF CHILD Arthur Jay
PLACE OF BIRTH Ahsahka Idaho DATE OF BIRTH Dec 13 1931 SEX OF CHILD boy

- 1. Number of children born to this mother, including present birth 5
- 2. Number born alive and now living one girl Arthur Jay
- 3. Born alive but now dead 4 boys that are dead
- 4. Number of children still born _____

(Please write plainly)

Information with reference to
FATHER
Scott Jay
(Full Name)
Ahsahka Idaho
(Residence)
Age at last birthday 41
Nebraska
(Birthplace)
Labor on Rail Road Section
(Occupation)

Information with reference to
MOTHER
Mrs Edna Miller Jay
(Full Name)
Ahsahka Idaho
(Residence)
Age at last birthday 26
Ahsahka Idaho
(Birthplace)
not able to work blind for
(Occupation)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,
Lewis Williams
Lewis Williams
Special Agent, Bureau of the Census.

632-247,027-399
RECEIVED JAN 7 1931
PLACE OF BIRTH

COUNTY OF

Franklin

PRECINCT OF

TOWN OR VILLAGE OF

CITY OF

Preston

STATE BOARD OF HEALTH FILE NO.

CERTIFICATE OF BIRTH

STATE OF

IDAHO

187230

STREET AND NO.

(If in Hospital or other Institution, give its Name instead of Street and Number)

FULL NAME OF CHILD

(If child is not yet named, make supplemental report as directed)

SEX OF CHILD <u>M-</u>	TWIN, TRIPLET, OR OTHER? (To be answered in event of plural births)	NUMBER IN ORDER OF BIRTH	PREMATURE FULL TERM <input checked="" type="checkbox"/>	LEGITIMATE? <u>yes</u>	DATE OF BIRTH <u>Dec 17</u> , 19 <u>30</u> (MONTH) (DAY) (YEAR)
FATHER FULL NAME <u>Charles Oliver Anderson</u> RESIDENCE (USUAL PLACE OF ABODE) <u>Preston Idaho</u> COLOR OR RACE <u>W</u> AGE AT LAST BIRTHDAY <u>31</u> (YEARS) BIRTHPLACE (CITY OR PLACE) <u>Norway</u> (STATE OR COUNTRY) OCCUPATION TRADE, PROFESSION, OR PARTICULAR KIND OF WORK DONE, AS SPINNER, SAWYER, BOOKKEEPER, ETC. <u>Farmer</u> INDUSTRY OR BUSINESS IN WHICH WORK WAS DONE, AS SILK MILL, SAWMILL, BANK, ETC.			MOTHER FULL MAIDEN NAME <u>Ersa M Bright</u> RESIDENCE (USUAL PLACE OF ABODE) <u>Preston Idaho</u> COLOR OR RACE <u>W</u> AGE AT LAST BIRTHDAY <u>30</u> (YEARS) BIRTHPLACE (CITY OR PLACE) <u>Richmond</u> (STATE OR COUNTRY) <u>Utah</u> OCCUPATION TRADE, PROFESSION, OR PARTICULAR KIND OF WORK DONE, AS HOUSEKEEPER, TYPIST, NURSE, CLERK, ETC. <u>H.W.</u> INDUSTRY OR BUSINESS IN WHICH WORK WAS DONE, AS OWN HOME, LAWYER'S OFFICE, SILK MILL, ETC.		
NUMBER OF CHILDREN OF THIS MOTHER (AT TIME OF THIS BIRTH AND INCLUDING THIS CHILD) (a) BORN ALIVE AND NOW LIVING <u>1</u> (b) BORN ALIVE BUT NOW DEAD (c) STILLBORN <u>1</u>					

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I HEREBY CERTIFY THAT I ATTENDED THE BIRTH OF THIS CHILD WHO WAS Stillborn AT 3:15 M. ON THE DATE ABOVE STATED.
(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(SIGNATURE)

DATE 12-17-30

(PHYSICIAN OR MIDWIFE)

GIVEN NAME ADDED FROM SUPPLEMENTAL REPORT

ADDRESS OF PHYSICIAN OR MIDWIFE

FILED 1/3/31, 19

REGISTRAR

REGISTRAR

REGISTERED NO. 292

Information for Physicians, Midwives, Parents and Others Required to Report Births

REPORTS

Section 5051, Compiled Laws of Utah, 1917. That it shall be the duty of the Attending Physician or Midwife to file a certificate of birth, giving all the particulars required by this Act, with the local registrar of the district in which the birth occurred, within ten days after the date of birth. And if there be no attending physician or midwife, then it shall be the duty of the Father of the child, Householder or Owner of the premises, Manager or Superintendent of Institution in which the birth occurred, to file said certificate of birth with the local registrar within three days after the birth.

EVERY ITEM OF INFORMATION IS IMPORTANT AND MUST BE SUPPLIED

The Full Name of the child is necessary for identification. If the child is not named when the report is made, get a blank from local registrar and make return of name as soon as child is named.

DO NOT OMIT ANY FACTS RELATING TO THE PARENTS OF THE CHILD

Section 5055, Compiled Laws of Utah, 1917, provides that: * * * "All Physicians, Midwives, Informants * * * connected with any case, and all other persons having knowledge of the facts, are hereby required to furnish such information as they may possess regarding any birth or death, upon demand of the State Registrar, in person, or by mail, or through the local registrar." * * * The State Registrar will not accept as complete a certificate with this data omitted without satisfactory explanation for failure to report same.

When no physician or midwife attended a birth the persons required to make the report in the order specified in Section 5051 shall strike out the words "I hereby certify that I attended the birth of this child," and write in lieu thereof the words "No Physician or Midwife," filling out the remainder of the certificate as the law requires and sign as father, householder, etc., as the case may be, with his address.

INSTRUCTIONS TO LOCAL REGISTRARS

Read carefully the law relating to the registration of births and do not allow your supply of blanks to become exhausted before requesting more.

Carefully examine each certificate as soon as it is filed, and if the facts required by law are not all supplied, return same for complete report. Enter the date of filing in your office immediately; give the certificate its proper registered number and make a copy of the original certificate for your local record. If the name of the child is not reported give the person who made the return a blank for supplemental report of name and direct that it be sent to you as soon as the child is named.

Send all original certificates to the State Board of Health on or before the fifth of the month. If the supplemental report of name of child has not yet been filed, send the certificate and forward the latter report as soon as received after entering name or other fact on your copy. If the child died before being named, the report should be made with the statement "died unnamed."

PENALTY

Section 5059, Compiled Laws of Utah, 1917. And any physician or midwife in attendance upon a case of confinement, or any other person charged with responsibility for reporting births, in the order named in Section 5051 of this Act, who shall neglect or refuse to file a proper certificate of birth with a local registrar, within the time required by this Act, shall be deemed guilty of a misdemeanor. * * * And any registrar, or deputy registrar, who shall neglect or fail to enforce the provisions of this Act in his district, or shall neglect or refuse to perform any of the duties imposed upon him by this Act or by the instructions and direction of the State Registrar, shall be deemed guilty of a misdemeanor. * * * Any person convicted of a misdemeanor under the provisions of this Act, shall be fined in any sum not less than ten dollars nor more than two hundred dollars.

Blank birth certificates may be obtained from Local Board of Health, Local Registrars or the State Board of Health.

Statement of Occupation.—Make some entry in this section for each parent. For a woman whose only occupation is that of home housework, write *housework* in answer to first Question and *own home* in answer to second Question. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as *housekeeper—private family*, *cook—hotel*, etc. For a person who has no occupation whatever write *none*.

To be complete, an occupation return must state:

The trade, profession, or particular kind of work done.

The industry or business in which the work is done.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as *spinner*, *weaver*, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as *grocery store*, *soap factory*, *cotton mill*, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as *civil engineer*, *mechanical engineer*, *mining engineer*, *stationary engineer*, etc. Avoid the term "laborer" when a more precise statement of occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as *carpenter*, *painter*, *machinist*, etc. Distinguish carefully between *retail merchants* and *wholesale merchants*. A person who sells goods should be called a *salesman* and not a *clerk*.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH **RECEIVED JAN 2 1931** STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
County of Fremont
City of St Anthony
No. _____ St. Registration District No. 99 State File No. **S 187259**
Hospital _____ Primary Registration District No. 2177 Local Registrar's No. 1119
FULL NAME OF CHILD St. Anthony
(Certificate of no value without full name of child.)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legiti- mate?	Date birth	(Month)	(Day)	(Year)
	(To be answered only in event of plural births)				<u>Nov. 13</u>			<u>1920</u>

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth <u>0</u> Number of child of this mother now living, including present birth <u>0</u>	
FATHER FULL NAME <u>Wilford Leell Wardle</u> RESIDENCE <u>Parker</u> COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>29</u> (Years) BIRTHPLACE _____ OCCUPATION <u>Laborer</u>	MOTHER FULL MAIDEN NAME <u>Rula Eugene</u> RESIDENCE <u>Parker</u> COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>19</u> (Years) BIRTHPLACE <u>Salem</u> OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 10. A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. Allison
M.D.
(Physician or midwife)

Give names added from a supplemental report.
_____, 192_____
Registrar.

Address _____
Filed Dec 31 1920 Lowman
Registrar.

*to file
ent. changed*

187259

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

LEWIS WILLIAMS
SPECIAL AGENT

Boise, Idaho. JAN 28 1931

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due time.

FULL NAME OF CHILD unchristianed

PLACE OF BIRTH Hermana Ida DATE OF BIRTH 17th of Nov. SEX OF CHILD Boy

1. Number of children born to this mother, including present birth 1 Child
2. Number born alive and now living none
3. Born alive but now dead none
4. Number of children stillborn born dead

(Please write plainly)

Mr Wilford D Hardle

Information with reference to
FATHER

Wilford Dell Hardle
(Full name)

Hermana Idaho
(Residence)

Age at last birthday 29 yrs

Parker Ida
(Birthplace)

Labor
(Occupation)

Information with reference to
MOTHER

Miss Ula Veloura Pugm
(Full MAIDEN name)

Hermana Ida
(Residence)

Age at last birthday 19 yrs

Salem Ida
(Birthplace)

(Occupation)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

Lewis Williams

Lewis Williams

Special Agent, Bureau of the Census.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

386-126-027-759
PLACE OF BIRTH

County of Jerome
City of Jerome
No. St.

(If born in hospital or institution
give name.)

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>Dec 26</u> 19 <u>30</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Oxydol

Number of child of this mother, including present birth 7 (a) Born alive and now living 6

Born alive but now dead 1 Stillborn 1

FATHER FULL NAME <u>Adam Edgar Thompson</u>	MOTHER FULL MAIDEN NAME <u>Blanch Perkins</u>
--	--

Residence (Usual place of abode) Jerome Idaho

If non-resident, give place and State

Color or race White Age at last Birthday 40 (Years)

Birthplace Utah (City and State or County)

Occupation Farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 12 - P. M. on the date above stated.

(Signature) Chas F Zeller

(Physician or midwife)

Address Jerome Idaho

Filed 12/27/1930 Chas F Zeller

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

RECEIVED JAN 9 1931
S187321

Registration District No. 18 State File No. S187321

Prim. Registration District No. Local Registrar's No.

UNITED STATES
DEPARTMENT OF JUSTICE
BUREAU OF PRISONS
WASHINGTON, D. C.

Primo Registration District No. (Last) Name of the
Registration District No. (First) Name of the

CONFIDENTIAL TO PERSONNEL OF THE FBI

U.S. AIR FORCE, 1954

10. 242
b6
b7C

4-11-68

Report of child of this mother including present and past history

1. NAME
 2. DATE
 3. TIME
 4. LOCATION
 5. REMARKS
 6. SIGNATURE
 7. INITIALS
 8. DATE
 9. TIME
 10. LOCATION
 11. REMARKS
 12. SIGNATURE
 13. INITIALS
 14. DATE
 15. TIME
 16. LOCATION
 17. REMARKS
 18. SIGNATURE
 19. INITIALS
 20. DATE
 21. TIME
 22. LOCATION
 23. REMARKS
 24. SIGNATURE
 25. INITIALS
 26. DATE
 27. TIME
 28. LOCATION
 29. REMARKS
 30. SIGNATURE
 31. INITIALS
 32. DATE
 33. TIME
 34. LOCATION
 35. REMARKS
 36. SIGNATURE
 37. INITIALS
 38. DATE
 39. TIME
 40. LOCATION
 41. REMARKS
 42. SIGNATURE
 43. INITIALS
 44. DATE
 45. TIME
 46. LOCATION
 47. REMARKS
 48. SIGNATURE
 49. INITIALS
 50. DATE
 51. TIME
 52. LOCATION
 53. REMARKS
 54. SIGNATURE
 55. INITIALS
 56. DATE
 57. TIME
 58. LOCATION
 59. REMARKS
 60. SIGNATURE
 61. INITIALS
 62. DATE
 63. TIME
 64. LOCATION
 65. REMARKS
 66. SIGNATURE
 67. INITIALS
 68. DATE
 69. TIME
 70. LOCATION
 71. REMARKS
 72. SIGNATURE
 73. INITIALS
 74. DATE
 75. TIME
 76. LOCATION
 77. REMARKS
 78. SIGNATURE
 79. INITIALS
 80. DATE
 81. TIME
 82. LOCATION
 83. REMARKS
 84. SIGNATURE
 85. INITIALS
 86. DATE
 87. TIME
 88. LOCATION
 89. REMARKS
 90. SIGNATURE
 91. INITIALS
 92. DATE
 93. TIME
 94. LOCATION
 95. REMARKS
 96. SIGNATURE
 97. INITIALS
 98. DATE
 99. TIME
 100. LOCATION
 101. REMARKS
 102. SIGNATURE
 103. INITIALS
 104. DATE
 105. TIME
 106. LOCATION
 107. REMARKS
 108. SIGNATURE
 109. INITIALS
 110. DATE
 111. TIME
 112. LOCATION
 113. REMARKS
 114. SIGNATURE
 115. INITIALS
 116. DATE
 117. TIME
 118. LOCATION
 119. REMARKS
 120. SIGNATURE
 121. INITIALS
 122. DATE
 123. TIME
 124. LOCATION
 125. REMARKS
 126. SIGNATURE
 127. INITIALS
 128. DATE
 129. TIME
 130. LOCATION
 131. REMARKS
 132. SIGNATURE
 133. INITIALS
 134. DATE
 135. TIME
 136. LOCATION
 137. REMARKS
 138. SIGNATURE
 139. INITIALS
 140. DATE
 141. TIME
 142. LOCATION
 143. REMARKS
 144. SIGNATURE
 145. INITIALS
 146. DATE
 147. TIME
 148. LOCATION
 149. REMARKS
 150. SIGNATURE
 151. INITIALS
 152. DATE
 153. TIME
 154. LOCATION
 155. REMARKS
 156. SIGNATURE
 157. INITIALS
 158. DATE
 159. TIME
 160. LOCATION
 161. REMARKS
 162. SIGNATURE
 163. INITIALS
 164. DATE
 165. TIME
 166. LOCATION
 167. REMARKS
 168. SIGNATURE
 169. INITIALS
 170. DATE
 171. TIME
 172. LOCATION
 173. REMARKS
 174. SIGNATURE
 175. INITIALS
 176. DATE
 177. TIME
 178. LOCATION
 179. REMARKS
 180. SIGNATURE
 181. INITIALS
 182. DATE
 183. TIME
 184. LOCATION
 185. REMARKS
 186. SIGNATURE
 187. INITIALS
 188. DATE
 189. TIME
 190. LOCATION
 191. REMARKS
 192. SIGNATURE
 193. INITIALS
 194. DATE
 195. TIME
 196. LOCATION
 197. REMARKS
 198. SIGNATURE
 199. INITIALS
 200. DATE
 201. TIME
 202. LOCATION
 203. REMARKS
 204. SIGNATURE
 205. INITIALS
 206. DATE
 207. TIME
 208. LOCATION
 209. REMARKS
 210. SIGNATURE
 211. INITIALS
 212. DATE
 213. TIME
 214. LOCATION
 215. REMARKS
 216. SIGNATURE
 217. INITIALS
 218. DATE
 219. TIME
 220. LOCATION
 221. REMARKS
 222. SIGNATURE
 223. INITIALS
 224. DATE
 225. TIME
 226. LOCATION
 227. REMARKS
 228. SIGNATURE
 229. INITIALS
 230. DATE
 231. TIME
 232. LOCATION
 233. REMARKS
 234. SIGNATURE
 235. INITIALS
 236. DATE
 237. TIME
 238. LOCATION
 239. REMARKS
 240. SIGNATURE
 241. INITIALS
 242. DATE
 243. TIME
 244. LOCATION
 245. REMARKS
 246. SIGNATURE
 247. INITIALS
 248. DATE
 249. TIME
 250. LOCATION

It is noted that the above information is being provided to you for your information only and is not to be used for any other purpose.

.....

Color in color
at last (Hilltop)
S (area)

(color in color) at last (Hilltop)
S (area)

(City and State or Country)

100-443887-100

CERTIFICATE OF ATTENDING PHYSICIAN ON MARCH 1961

(2) 1 8 8 5

I hereby certify that I attended the birth of this child, who was

DATE - 10/08/2019

There were no attending physicians at midwife. Then the father, householder, should make his return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Page: 55A

el... ..

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 13261

PLACE OF DEATH

County of Jerome

City of Jerome

CERTIFICATE OF DEATH

Registration District No. 18

Primary Registration District No. _____ Local Registrar's No. _____

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Thompson

(a) Residence. No. _____ St. _____

(Usual place of abode.)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word.) Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 26/30

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
6 1/2 0 0 0 30 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Jerome Idaho
(State or country)

10. NAME OF FATHER Adam Edgar Thompson

11. BIRTHPLACE OF FATHER (city or town) Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Blanch Perkins

13. BIRTHPLACE OF MOTHER (city or town) Utah
(State or Country)

14. Informant A. E. Thompson
(Address) Jerome Idaho

15. Filed 12/27, 1930 Chas H Zeller
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 26, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26, 1930, to Dec. 26, 1930

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Still Born infant
Toxic from mother (acute nephritis)
tardious labor

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

Signed C. H. Zeller M. D.
12/27, 1930 (Address) Jerome, Idaho

19. Place of Burial, Cremation, or Removal _____ Date of Burial _____

20. Undertaker _____ Address _____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
Physician should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

1875217

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of** (name origin); "Cancer" is less definite: avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED JAN 7 1981

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Mr. Price
City of Lewiston
No. _____ St. _____

CERTIFICATE OF BIRTH

187487

Registration District No. 96 State File No. _____
(If born in hospital or institution
give name.) Birth Registration District No. 1009 Local Registrar's No. _____

FULL NAME OF CHILD Maccarnage St. sid Ma
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	{ and }	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Dec. 25</u> 19 <u>30</u> (Month) (Day) (Year)
--------------	------------------------------	---------	--------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? X

Number of child of this mother, including present birth 1 (a) Born alive and now living 3

Born alive but now dead 1 Stillborn _____

FULL NAME <u>Lynn Schwandt</u>	FATHER	FULL MAIDEN NAME _____	MOTHER
-----------------------------------	--------	------------------------------	--------

Residence (Usual place of abode) Lewiston Ida Residence (Usual place of abode) Lewiston Ida

If non-resident, give place and State _____ If non-resident, give place and State _____

Color or race White Age at last Birthday 23 Color or race White Age at last Birthday 19
(Years) (Years)

Birthplace Penetlon Oregon Birthplace Arbush, Ida
(City and State or County) (City and State or County)

Occupation Farmer Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive Stillborn at A. M.
on the date above stated.

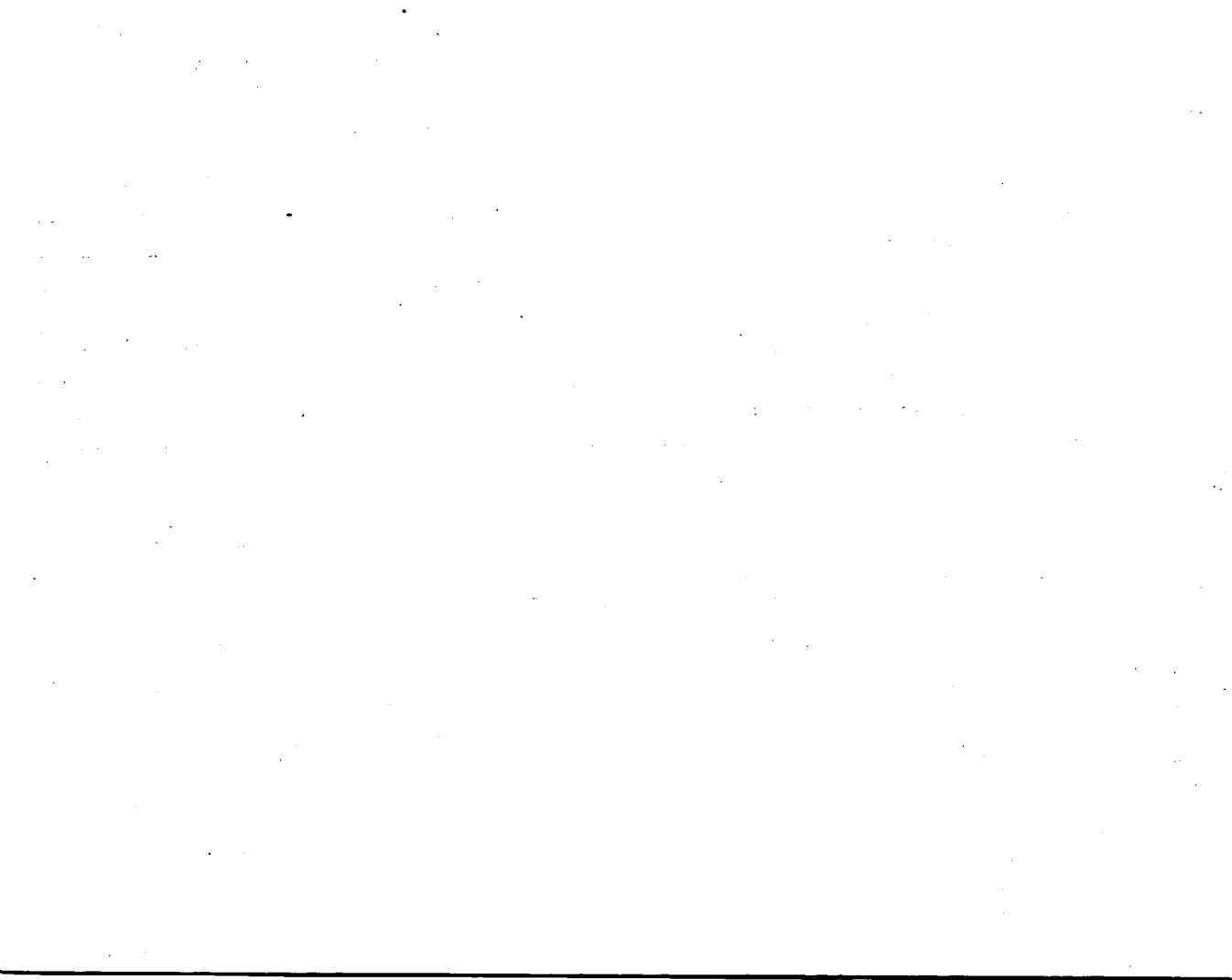
(Signature) Dr. J. G. Henry

(Physician or midwife)

Address Lewiston Idaho

Filed 1-2 1931 J. M. Lyle
647150 Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

639-103-935-983
PLACE OF BIRTH Idaho JAN 7 1931
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
COUNTY OF Payette
CITY OF Luna
No. St. Joseph St.
(If born in hospital or institution give name.)
Registration District No. _____ State File No. 187494
Prim. Registration District No. _____ Local Registrar's No. _____
FULL NAME OF CHILD Eugene Frank Flint
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin <input type="checkbox"/> Triplet <input checked="" type="checkbox"/> or other? <input type="checkbox"/>	and { Number in order of birth <u>1</u> }	Legitimate? <u>yes</u>	Date of birth <u>Dec 3</u> 19 <u>30</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What prophylactic was used to prevent Ophthalmia Neonatorum? 1% AgNO3
Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME <u>Alben Flint</u>	FULL MAIDEN NAME <u>Elizabeth Hollenhorst</u>		
Residence (Usual place of abode) <u>Cullesoe Id.</u>	Residence (Usual place of abode) <u>Idaho</u>		
If nonresident, give place and State _____	If nonresident, give place and State _____		
Color or race <u>White</u> Age at last Birthday <u>34</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>27</u> (Years)		
Birthplace <u>Osage, Iowa</u> (City and State or Country)	Birthplace <u>Europe, Id.</u> (City and State or Country)		
Occupation <u>Mail Carrier</u>	Occupation <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 9:30 M.
on the date above stated. (Signature) William P. H. Hatfield

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife) _____
Address Luna
Filed 2 1931 JAN 11 1931
Registrar

MARGIN RESERVED FOR BINDING

1874911

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Habel

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 78499

PLACE OF DEATH
County of Benewah
City of Leoviston

Registration District No.
Primary Registration District No.

Local Registrar's No.

(No. W Joseph)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Flint

RECEIVED JAN 12 1930
206

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS				
3. SEX <u>m</u>	4. COLOR OR RACE <u>w</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Infant</u>		
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of				
6. DATE OF BIRTH (month, day and year)				
7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
<u>Still Born</u>				
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work <u>Still Born</u>				
(b) General nature of industry, business, or establishment in which employed (or employer)				
(c) Name of employer				
9. BIRTHPLACE (city or town) <u>Leoviston Ida</u> (State or country)				
10. NAME OF FATHER <u>Alden Flint</u>				
11. BIRTHPLACE OF FATHER (city or town) <u>Idaho</u> (State or Country)				
12. MAIDEN NAME OF MOTHER <u>Elizabeth Hollingsworth</u>				
13. BIRTHPLACE OF MOTHER (city or town) <u>Idaho</u> (State or Country)				
14. Informant <u>Alden Flint</u> (Address) <u>Cassida at Ida</u>				
15. Filed _____, 19____ Registrar				

MEDICAL CERTIFICATE OF DEATH	
16. DATE OF DEATH	<u>Dec 3</u> 19 <u>30</u> (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from <u>Dec 3</u> , 19 <u>30</u> , to _____, 19____ that I last saw h_____ alive on _____, 19____ and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Cerebral fracture</u> (duration) yrs. mos. ds. CONTRIBUTORY <u>Forcep Delivery</u> (Secondary) (duration) yrs. mos. ds.	
18. Where was disease contracted if not at place of death? _____ Did an operation precede death? <u>no</u> Date of _____ Was there an autopsy? <u>no</u> What test confirmed diagnosis? <u>Physical signs</u> (Signed) <u>Wm. H. H. H. H. H.</u> M. D. 12/3/30, 19____ (Address) <u>Leoviston</u>	
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
19. Place of Burial, Cremation, or Removal <u>Leoviston</u>	Date of Burial 19____
20. Undertaker	Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

663-112-

PLACE OF BIRTH

RECEIVED JAN 6 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 187568

County of Shoshone

City of Kellogg

No. _____ St. _____

Registration District No. 123

File No. _____

Hospital HARDNER

Primary Registration District No. 2201

Registered No. 185

FULL NAME OF CHILD none

(Certificate of no value without full name of child.)

Sex of Child Male

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

Yes

Date of
birth

Nov. 12 1920
(Month) (Day) (Year)

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth.....

Number of child of this mother now living, including present birth.... 10

FULL
NAME

FATHER

Wallace Glen Hoof

RESIDENCE

Silver King

COLOR

White

AGE AT LAST
BIRTHDAY

40

(Years)

BIRTHPLACE

Salt Lake City

OCCUPATION

Metallurgist

FULL
MAIDEN
NAME

MOTHER

Doris Eleanor Tennyson

RESIDENCE

Silver King

COLOR

White

AGE AT LAST
BIRTHDAY

27

(Years)

BIRTHPLACE

N. Dakota

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn,
on the date above stated.

9:27 A.
(Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

Geoff Kennett, M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address

Kellogg, Idaho

Filed

Dec. 28 1930 Mrs. Helen B. Bride

Registrar.

Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 6 1931
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73395

County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201

Local Registrar's No. 65

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

706

2. FULL NAME Baby Woolf

(a) Residence. No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX <u>Male</u>	4. COLOR OR RACE <u>white</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
5a. If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____		
6. DATE OF BIRTH (month, day and year) <u>Nov. 12, 1930</u>		
7. AGE <u>Stillborn</u>	Years Months Days	If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (city or town) Kellogg, Idaho
(State or country)

10. NAME OF FATHER <u>Mr. S. Woolf</u>
11. BIRTHPLACE OF FATHER (city or town) (State or Country) <u>Salt Lake City, Utah</u>
12. MAIDEN NAME OF MOTHER <u>Dora Tennyson</u>
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) <u>Mayville, N. Dakota</u>

14. Informant Mr. S. Woolf
(Address) Kellogg, Idaho

15. Filed Dec 28, 1930 Miss Helen A. Bried
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. 12 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12, 1930, to Nov 12, 1930, that I last saw him alive on Nov 12, 1930 and that death occurred, on the date stated above, Stillborn.
The CAUSE OF DEATH* was as follows:

Still born - mother threatened with eclampsia. Uterine full of albumen. Labor coming on spontaneously.
CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. mos. ds.

18. Where was disease contracted if not at place of death? _____
Did an operation precede death? _____ Date of _____
Was there an autopsy? _____
What test confirmed diagnosis? _____
(Signed) Scott J. Jones M. D.
Dec 20, 1930 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kellogg, Idaho Date of Burial Nov 12, 1930

20. Undertaker M. C. Thornhill Address Kellogg, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JAN 6 1931

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

187593

County of Teton
City of Victor R.D.
No. _____ St. _____

Registration District No. 77 State File No. _____

(If born in hospital or institution
give name.)

Prim. Registration District No. 9176 Local Registrar's No. 50

FULL NAME OF CHILD

Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>no</u>	Date of birth <u>12-14-1930</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------	----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead _____ Stillborn 1

FATHER
FULL NAME Don Ballard
Residence (Usual place of abode) Victor R.D.
If nonresident, give place and State _____
Color or race White Age at last Birthday 34 (Years)
Birthplace Victor, Ida
(City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Ida Collins
Residence (Usual place of abode) Victor R.D.
If nonresident, give place and State _____
Color or race White Age at last Birthday 36 (Years)
Birthplace Isle Man
(City and State or Country)
Occupation Working girl

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

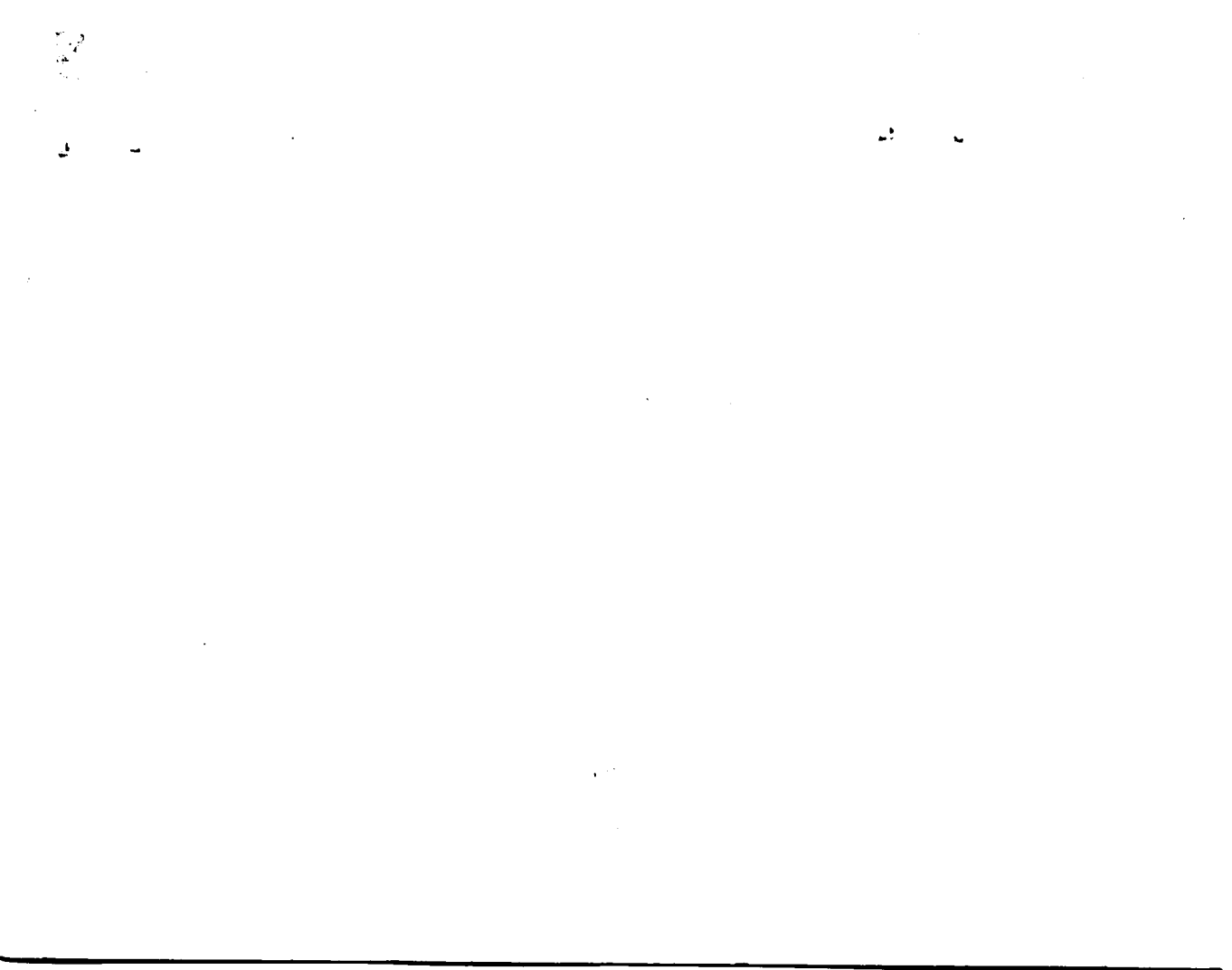
I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 8:30 P. M.
on the date above stated.

(Signature) Ch. H. Harkness

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address Triggs, Idaho
Filed 12-30-1930 Martha Marker
Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC JAN 6 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73133

PLACE OF DEATH
County of Teton
City of Chapin

Registration District No. 77
Primary Registration District No. 2176

Local Registrar's No. 15

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

206

2. FULL NAME Stillborn

(a) Residence. No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____

6. DATE OF BIRTH (month, day and year) December 14-30
7. AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Infant
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (city or town) Chapin
(State or country) Idaho

10. NAME OF FATHER Don Ballard

11. BIRTHPLACE OF FATHER (city or town) Payson
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Ada Ballin

13. BIRTHPLACE OF MOTHER (city or town) Isle Man
(State or Country) Idaho

14. Informant Mrs John Nichell
(Address) Victor Idaho

15. Filed 12-15-30 Martha Marker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-14, 1930, to 12-14, 1930
that I last saw him alive on _____, 19____, at _____
and that death occurred, on _____ date stated above, at 8:30 p.m.
The CAUSE OF DEATH* was as follows: asphyxiation

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Profound miliary
(Secondary) sepsis
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____
Did an operation precede death? _____ Date of _____
Was there an autopsy? _____

What test confirmed diagnosis? _____
(Signed) J. T. Parkinson M.D.
12-15-30 (Address) Dugood

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Darby, Idaho Date of Burial 12-16-1930

20. Undertaker _____ Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Twinn Falls
City of Twinn Falls

No. 7 St. Cox Gen Hosp

(If born in hospital or institution give name.)

FULL NAME OF CHILD Still born

(If stillborn, substitute the word "Stillbirth" for name of child)

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE **RECEIVED**

JAN 10 1931
187603

Registration District No. 27 State File No. 2085

Prim. Registration District No. 2085 Local Registrar's No. 521

Sex of Child <u>Male</u>	Twins Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth <u>Dec 13</u> 19 <u>30</u> (Month) (Day) (Year)
--------------------------	-------------------------------	-----	--------------------------------	-------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 6 (a) Born alive and now living 3

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME <u>Marion Scott Hafer</u>	FULL MAIDEN NAME <u>Irene Vernon</u>
Residence (Usual place of abode) <u>337-3rd West</u>	Residence (Usual place of abode) <u>Twinn Falls</u>
If non-resident, give place and State <u>Twinn Falls</u>	If non-resident, give place and State _____
Color or race <u>W.</u> Age at last Birthday <u>31</u> (Years)	Color or race <u>W.</u> Age at last Birthday <u>29</u> (Years)
Birthplace <u>Council Grove</u> (City and State or County)	Birthplace <u>Holbrook Ida</u> (City and State or County)
Occupation <u>Carpenter</u>	Occupation <u>House wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 8 50 P. M. on the date above stated.

(Signature) Dr. John R. Morgan
Twinn Falls, Idaho
(Physician or midwife)

Address Twinn Falls Ida

Filed Jan 5 1931 Elizabeth J. Smith
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

I hereby certify that I attended the birth of this child, who was _____ at _____ on the date above stated. (Signature)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 Occupation _____
 City and State of County _____
 Birthplace _____
 Color of hair _____
 Color of eyes _____
 Date of birth _____
 If non-resident, give place and date _____
 Residence (if different from above) _____
 Remarks: Usual placental attachments _____
 If non-attached, give place and date _____
 Color of face _____
 Date of birth _____
 City and State of County _____

Full Name of Child _____
 Sex of Child _____
 Date of Birth _____
 Legitimacy _____
 State of Birth _____
 Date of Birth _____
 Number of Child of this mother including present birth _____
 Number of Child of this mother including present birth _____
 Born alive but now dead _____
 Born alive but now dead _____
 Full Name of Mother _____
 Date of Birth _____
 Legitimacy _____
 State of Birth _____
 Date of Birth _____
 Number of Child of this mother including present birth _____
 Number of Child of this mother including present birth _____
 Born alive but now dead _____
 Born alive but now dead _____

What prophylactic was used to prevent Ophthalmia Neonatorum? _____
 (To be filled out only in case of living child)
 Date of Birth _____
 Legitimacy _____
 State of Birth _____
 Date of Birth _____
 Number of Child of this mother including present birth _____
 Number of Child of this mother including present birth _____
 Born alive but now dead _____
 Born alive but now dead _____

Full Name of Child _____
 Sex of Child _____
 Date of Birth _____
 Legitimacy _____
 State of Birth _____
 Date of Birth _____
 Number of Child of this mother including present birth _____
 Number of Child of this mother including present birth _____
 Born alive but now dead _____
 Born alive but now dead _____
 Full Name of Mother _____
 Date of Birth _____
 Legitimacy _____
 State of Birth _____
 Date of Birth _____
 Number of Child of this mother including present birth _____
 Number of Child of this mother including present birth _____
 Born alive but now dead _____
 Born alive but now dead _____

STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 15631

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 27

Primary Registration District No. 2085

Local Registrar's No. 216

(No. Twin Falls County Reg.)

(If death occurred in a hospital or institution, give its name instead of street and number)

2. FULL NAME Baby Hafer

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min. X X X X

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Twin Falls (State or country) Ida.

10. NAME OF FATHER Marion S. Hafer

11. BIRTHPLACE OF FATHER (city or town) Kansas (State or Country) _____

12. MAIDEN NAME OF MOTHER Iren Iverson

13. BIRTHPLACE OF MOTHER (city or town) Idaho (State or Country) _____

14. Informant M. S. Hafer (Address) 337 3rd ave n. City.

15. Filed 12/27, 1930 Elinor J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12 13 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw h_____ alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Endocarditis of Mother
Utterine Infection
Placenta Prezentaria
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) John R. Morgan, M. D.

_____, 19____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Twin Falls 12-15 1930

20. Undertaker Address

White Mortuary Twin Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Twin Falls

City of Twin Falls

No. 17 St. Co. & Gen.

(If born in hospital or institution
give name.)

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 37 State File No. 187608

Prim. Registration District No. 2085 Local Registrar's No. 516

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Dec</u> <u>10</u> <u>1930</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 2

FATHER
FULL NAME Frank E. Brown

Residence (Usual place of abode) Kimberly

If nonresident, give place and State

Color or race W. Age at last Birthday 29 (Years)

Birthplace Beechfork Tenn. (City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Mildred Mahan

Residence (Usual place of abode) Kimberly

If nonresident, give place and State

Color or race W. Age at last Birthday 21 (Years)

Birthplace Payette Ida. (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 8:50 P. M. on the date above stated.

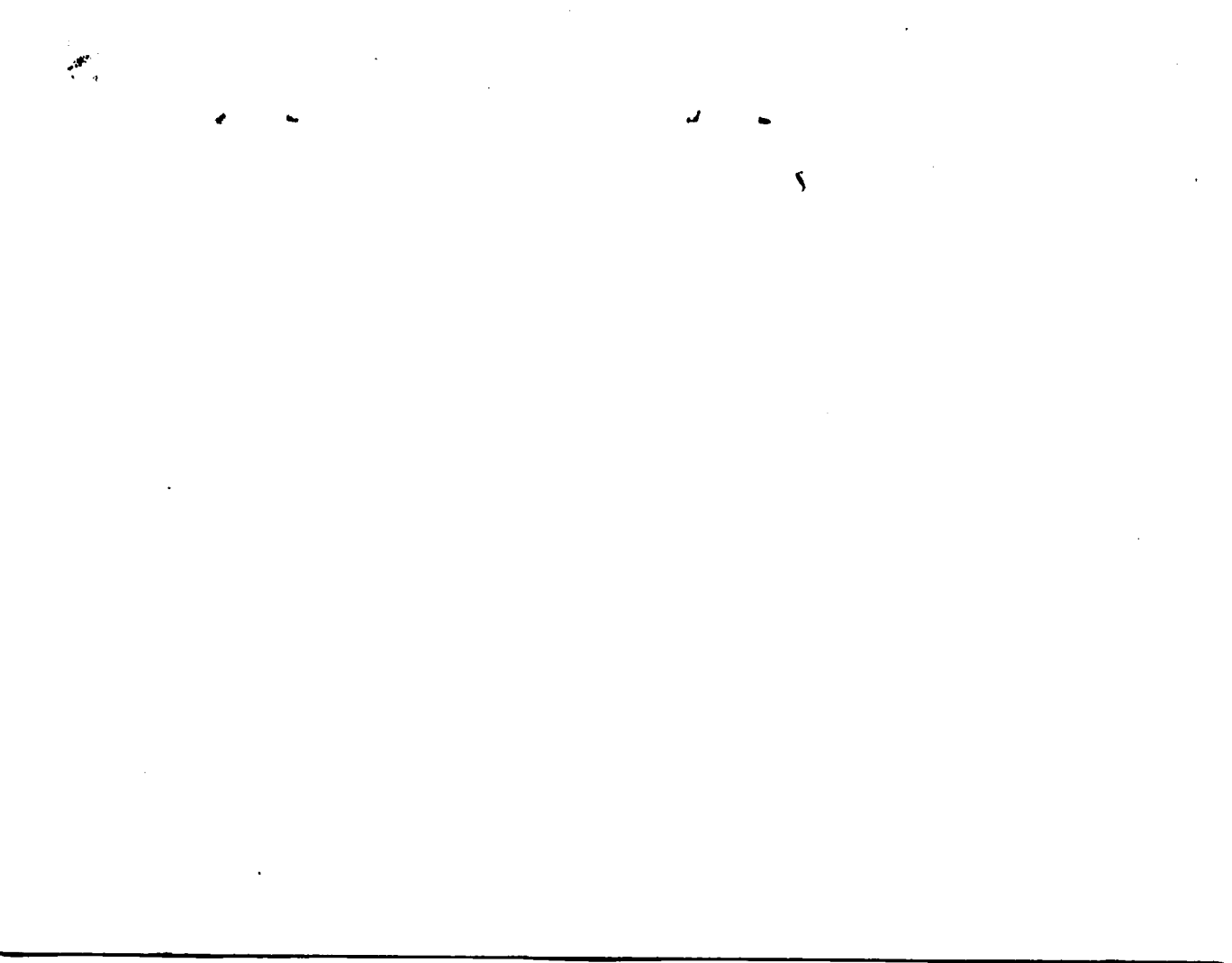
(Signature) John H. Loughlin

(Physician or midwife)

Address Twin Falls Ida.

Filed Jan 5 1931 Elizabeth J. Smith Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73349

PLACE OF DEATH
County of Twin Falls,
City of Twin Falls,

Registration District No. 37
Primary Registration District No. 2085

Local Registrar's No. 213

(No. County Gen. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Brown

(a) Residence. No. Kimberly Idaho. St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. Single, Married, Widowed, or Divorced (write the word) XXXX
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXXXXX		
6. DATE OF BIRTH (month, day and year) Dec. - 10th - 1930		
7. AGE --- Years	--- Months	--- Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work XXXXXX (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (city or town) Twin Falls, Idaho.
(State or country)

PARENTS

10. NAME OF FATHER Frank E. Brown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.
12. MAIDEN NAME OF MOTHER Mildred Lahnken
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant Frank E. Brown
(Address) Kimberly, Idaho.

15. Filled 12/27, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. 10th. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
19 to 19

that I last saw him alive on 19
and that death occurred, on the date stated above, at 9.30 PM

The CAUSE OF DEATH was as follows:
Still born - due to
to abnormal development of pregnancy
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Elizabeth J. Smith, M. D.
12-11-30 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal
Twin Falls Idaho. Date of Burial Dec. 11th 1930

20. Undertaker
Grossman Mortuary, Twin Falls, Ida. Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

DATE OF BIRTH 1939
County Boia
City Boia
No. St. Lukes St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

187713

Registration District No. 3 State File No. S 15
(If born in hospital or institution, give name.) Stillborn Baby Registration District No. 1004 Local Registrar's No. 15

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>7</u>	Twin Triplet or other? <u>and</u> { Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>Dec 16</u> 19 <u>30</u> (Month) (Day) (Year)
-----------------------	--	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 7 (a) Born alive and now living 4

Born alive but now dead 3 Stillborn One

FATHER FULL NAME <u>O. N. Harris</u>	MOTHER FULL MAIDEN NAME <u>Mildred Lummer</u>
---	--

Residence (Usual place of abode) Boia Ida

If non-resident, give place and State

Color or race White Age at last Birthday 28 (Years)

Birthplace Castool Mo. (City and State or County)

Occupation Laborer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 50P M. on the date above stated.

(Signature) W. R. Bosch

(Physician or midwife)

Address Boia Ida

Filed 1-13 1931 W. N. Chas Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

$$\frac{239}{n}$$

$$\frac{49}{19} = \frac{28}{47}$$

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No.

72941

PLACE OF DEATH

County of AdaCity of Boise

CERTIFICATE OF DEATH

Registration District No. 2Primary Registration District No. 1004(No. St. Lukes Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Harris.(a) Residence. No. 111. Ave. C. St.

(Usual place of abode.)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male.</u>	4. COLOR OR RACE <u>White.</u>	5. Single, Married, Widowed, or Divorced (write the word.) <u>Single.</u>
------------------------	-----------------------------------	---

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Dec. 16. 1930.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Idaho.
(State or country)

PARENTS

10. NAME OF FATHER Charles. M. Harris.11. BIRTHPLACE OF FATHER (city or town) Missouri.
(State or Country)12. MAIDEN NAME OF MOTHER Mildred Plummer.13. BIRTHPLACE OF MOTHER (city or town) Missouri.
(State or Country)14. Informant Charles. M. Harris.
(Address) 111. Ave. C. Boise, Idaho.15. Filed 12-18 1930 W. H. Phelan
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Stillborn Dec 16, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to....., 19.....

that I last saw him alive on....., 19.....

and that death occurred, on the date stated above, at.....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:Stillborn.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)(duration) yrs. 1 mos. ds.18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date of.....Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. H. Phelan, M. D.Dec 18, 1930 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Date of Burial

New Plymouth Ch 12/18 1930

20. Undertaker Address

Summers & Krebs. Boise, Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of** (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia, "PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

364-102-209-432
PLACE OF BIRTH

County of Bonner
City of Elmore
No. _____ St. _____

STATE OF IDAHO FEB 9 1931
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH 187897

(If born in hospital or institution
give name.)

Registration District No. 7F State File No. _____

Prim. Registration District No. 2155 Local Registrar's No. 1

FULL NAME OF CHILD Wilson Lodge
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u>✓</u> and <u>✓</u> Number in order of birth <u>✓</u>	Legitimate? <u>yes</u>	Date of birth <u>Oct. 2nd. 1930</u> (Month) (Day) (Year)
--------------------------	--	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? 1% Ag NO3

Number of child of this mother, including present birth 5 (a) Born alive and now living 2

Born alive but now dead 2 Stillborn 1

FATHER FULL NAME <u>Geo. F. Lodge</u>	MOTHER FULL MAIDEN NAME <u>Rose M. Kenzie</u>
--	--

Residence (Usual place of abode) Elmore, Idaho

If non-resident, give place and State _____

Color or race white Age at last Birthday 28 (Years)

Birthplace Brillwate, Mass. (City and State or County)

Occupation Farmers

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 9.50 A. M. on the date above stated.

(Signature) S. E. Ing

Physician
(Physician or midwife)

Address Bonner Ferry, Ida.

Filed Feb. 5 1931 Viola Allen
Deputy Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

1. Name of child
 2. Date of birth
 3. Place of birth
 4. Sex of child
 5. Race of child
 6. Religion of child
 7. Name of father
 8. Name of mother
 9. Name of physician
 10. Name of attending physician
 11. Name of nurse
 12. Name of midwife
 13. Name of other person
 14. Name of hospital
 15. Name of clinic
 16. Name of school
 17. Name of church
 18. Name of synagogue
 19. Name of mosque
 20. Name of other place of worship

NAME OF CHILD

(If born in hospital or institution, give name)

Registration District No. _____
 State File No. _____
 Local Registration District No. _____
 Local Registrar's No. _____

(To be answered in case of stillbirth)
 Sex of child _____
 Race of child _____
 Religion of child _____
 Name of father _____
 Name of mother _____
 Date of birth _____
 Place of birth _____
 Sex of child _____
 Race of child _____
 Religion of child _____
 Name of father _____
 Name of mother _____

When the child was born, was there any abnormality?

If so, describe the abnormality, including present birth _____
 If not, state and how known _____

If the child was born alive, was it ever ill? _____
 If so, describe the illness _____

If the child was born alive, was it ever dead? _____
 If so, describe the death _____

If the child was born alive, was it ever buried? _____
 If so, describe the burial _____

If the child was born alive, was it ever cremated? _____
 If so, describe the cremation _____

If the child was born alive, was it ever interred? _____
 If so, describe the interment _____

If the child was born alive, was it ever buried? _____
 If so, describe the burial _____

If the child was born alive, was it ever cremated? _____
 If so, describe the cremation _____

If the child was born alive, was it ever interred? _____
 If so, describe the interment _____

If the child was born alive, was it ever buried? _____
 If so, describe the burial _____

If the child was born alive, was it ever cremated? _____
 If so, describe the cremation _____

If the child was born alive, was it ever interred? _____
 If so, describe the interment _____

If the child was born alive, was it ever buried? _____
 If so, describe the burial _____

If the child was born alive, was it ever cremated? _____
 If so, describe the cremation _____

If the child was born alive, was it ever interred? _____
 If so, describe the interment _____

If the child was born alive, was it ever buried? _____
 If so, describe the burial _____

If the child was born alive, was it ever cremated? _____
 If so, describe the cremation _____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72318

PLACE OF DEATH
County of Banner
City of Elmira

Registration District No. 78
Primary Registration District No. 2155

Local Registrar's No. 73

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Lodge

(a) Residence. No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6. DATE OF BIRTH (month, day and year) Oct. 2, 1930

7. AGE Stillbirth Years _____ Months _____ Days _____ If LESS than 1 day, hrs. or min. _____

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (city or town) Elmira (State or country) Idaho

10. NAME OF FATHER James Lodge

11. BIRTHPLACE OF FATHER (city or town) Bridgewater (State or Country) Mass.

12. MAIDEN NAME OF MOTHER Lena McKenzie

13. BIRTHPLACE OF MOTHER (city or town) Elmira (State or Country) Idaho

14. Informant James Lodge (Address) Elmira, Idaho

15. Filed Oct. 2, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 2 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
that I last saw h_____ alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

Ectopic separation of the placenta
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) E. S. My, M. D. Oct. 3, 1930 (Address) Banner Ferry, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal M. C. Arthur, Idaho Date of Burial Oct. 5, 1930

20. Undertaker Moore Mortuary Address Sandpoint, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bannock
City of Banner Ferry
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

187952

Registration District No. 29 State File No. _____

(If born in hospital or institution
give name.)

Prim Registration District No. 5156 Local Registrar's No. _____

FULL NAME OF CHILD

Baby Frank

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u>✓</u>	and	Number in order of birth <u>✓</u>	Legiti- mate? <u>yes</u>	Date of birth <u>Dec. 4th</u> 19 <u>30</u>
(To be answered only in event of plural births)				(Month)	(Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead _____ Stillborn 1

FATHER FULL NAME <u>Blonde Frank</u>	MOTHER FULL MAIDEN NAME <u>Rose Wolfe</u>
---	--

Residence (Usual place of abode) Banner Ferry, Ida

If non-resident, give place and State _____

Color or race white Age at last Birthday 38 (Years)

Birthplace Idaho (City and State or County)

Occupation laborer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 9 A M.
on the date above stated.

(Signature) SS Fy

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address Banner Ferry, Ida.

Filed Dec. 10-1930

Registrar

[illegible]

OCT 1 1966

U. S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

to vilo
on

Primo Registration District No. _____ Local Registrar No. _____
Registration District No. _____ State File No. _____

(It born in hospital of Washington
1920-1921)

KEEP NAME OF CHILD

It is important to substitute the word "substitute" for "change" in the title of the report.

Date of
 Birth
 (Month) (Day) (Year)
 Sex of
 Child
 (Male) (Female)

What methodology was used to prevent (diploma) cheating?

Report of case of this mother, showing a child with ... Born alive and now living

Stallone

100-443888-100

Residence (Usual place of abode) Residence (Usual place of abode)

1. non-terrestrial, give place and date

1. The first group of people who are not allowed to enter the country are those who are on the "No Fly List". This list is maintained by the Federal Bureau of Investigation (FBI) and the Department of Homeland Security. It includes individuals who are suspected of being involved in terrorism or other activities that could threaten the national security.

77001-60400 (10)

100-443887-100

INSTITUTION OF TECHNOLOGY PHRYNIA OR MICHIGAN

9-11-1964

on the date above stated.

There there was no attending physician or nurse with the father, householders, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RESTBDA

10114

(b) (5) DPP, (b) (5) ACP

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED FEB 3 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 73845

PLACE OF DEATH

County of Bonner

City of Bonner Ferry

CERTIFICATE OF DEATH

Registration District No. 27

Primary Registration District No. 2156

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Frank

(a) Residence. No. _____ St. _____

(Usual place of abode.)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S. if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 4 - 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min. Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Bonner Ferry
(State or country) Idaho

10. NAME OF FATHER Claude Frank

11. BIRTHPLACE OF FATHER (city or town) Penn.
(State or Country)

12. MAIDEN NAME OF MOTHER Rose Wolf

13. BIRTHPLACE OF MOTHER (city or town) Germany
(State or Country)

14. Informant Claude Frank
(Address) Bonner Ferry

15. Filed Dec. 4 19 30 Registrar J. R. Crouch

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 4th 19 30
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at 9 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Anencephalus

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted _____
if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) J. R. Crouch, M. D.
Dec. 4 - 19 30 (Address) Bonner Ferry, Idaho

19. Place of Burial, Cremation, or Removal Bonner Ferry, Idaho Date of Burial Dec 6 1930

20. Undertaker J. R. Crouch Address Bonner Ferry

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) SALEMAN, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications. as **Day laborer. Farm laborer. Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid House-keepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.,** Carcinoma, Sarcoma, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each.

PLACE OF BIRTH
County of Latah
City of Deary
No. Home St.
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH 188183

Registration District No. 46 State File No. 8
Prim. Registration District No. 2148 Local Registrar's No.
FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>Nov 18</u> 19 <u>30</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 3 (a) Born alive and now living 1

Born alive but now dead 2 Stillborn 1

FULL NAME <u>Harry Enoch Tracy</u> FATHER Residence (Usual place of abode) <u>Deary</u> If non-resident, give place and State <u> </u> Color or race <u>White</u> Age at last Birthday <u>37</u> (Years) Birthplace <u>Oregon</u> (City and State or County) Occupation <u>Bookman</u>	FULL MAIDEN NAME <u>Helda Ruth Lincer</u> MOTHER Residence (Usual place of abode) <u>Deary</u> If non-resident, give place and State <u> </u> Color or race <u>White</u> Age at last Birthday <u>26</u> (Years) Birthplace <u>Deary, Ida.</u> (City and State or County) Occupation <u>Housewife</u>
---	---

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive }
on the date above stated. { Stillborn } at 4 - 10 A. M.
(Signature) E. B. Parker
M. D.
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Booth, Ida.

Filed Nov 21 1930 E. B. Parker
Registrar.

THIS IS A COPY OF THE ORIGINAL RECORD OF THE BIRTH OF THE CHILD. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF BIRTHS AND DEATHS.

PLACE OF BIRTH

County of _____
City of _____
State of _____

It is hereby certified that the child named _____
(Name)

WAS BORN ON _____

At _____
City of _____
State of _____

It is hereby certified that the child named _____
(Name)

WAS BORN ON _____
At _____
City of _____
State of _____

It is hereby certified that the child named _____
(Name)

WAS BORN ON _____
At _____
City of _____
State of _____

It is hereby certified that the child named _____
(Name)

WAS BORN ON _____
At _____
City of _____
State of _____

2

STATE OF _____
DEPARTMENT OF _____
BUREAU OF _____

120183

Registration District No. _____
Local Registration No. _____

It is hereby certified that the child named _____
(Name)

At _____
City of _____
State of _____

It is hereby certified that the child named _____
(Name)

WAS BORN ON _____
At _____
City of _____
State of _____

It is hereby certified that the child named _____
(Name)

WAS BORN ON _____
At _____
City of _____
State of _____

It is hereby certified that the child named _____
(Name)

WAS BORN ON _____
At _____
City of _____
State of _____

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Lehigh
City of Salmon
No. De Hospital St.

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH **188205**

Registration District No. 41 State File No. S
Prim. Registration District No. 2-116 Local Registrar's No. 188205

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other?	{ and }	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Dec 8</u> 19 <u>30</u> (Month) (Day) (Year)
--------------------------	------------------------------	---------	--------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1 (a) Born alive and now living _____

Born alive but now dead _____ Stillborn 1

FULL NAME <u>Otto J. Vigner</u>	FATHER	FULL MAIDEN NAME <u>Jennie Jorman</u>	MOTHER
---------------------------------	--------	---------------------------------------	--------

Residence (Usual place of abode) Salmon

If non-resident, give place and State _____

Color or race W Age at last Birthday 29 (Years)
Color or race W Age at last Birthday 21 (Years)

Birthplace Id (City and State or County)
Birthplace Id (City and State or County)

Occupation Thoma Occupation Id

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 6 P M.
on the date above stated.
(Signature) St. Mayhew

(Physician or midwife)

Address Salmon

Filed Feb 10 1931 Chas Bellamy
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

000

City of _____
County of _____

I hereby certify that _____
is duly qualified as a _____
of said _____.

Dated this _____ day of _____,
A.D. 19____.

Subject to review to (b)(1)

Number of children 17-18 years old including present birth..

SECRET 7

2025
VOLUME

is non-existent. Give your name

100

Q I hereby certify that I attended the birth of this child, who was born

...and the

.....

S

Registration Number 70 State File No.

to call - 1961

1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.

... (b) ... (c) ... (d) ... (e) ... (f) ... (g) ... (h) ... (i) ... (j) ... (k) ... (l) ... (m) ... (n) ... (o) ... (p) ... (q) ... (r) ... (s) ... (t) ... (u) ... (v) ... (w) ... (x) ... (y) ... (z) ...

RECEIVED
JAN 10 1964

..... body is only found inside of

Birthdate: _____ Age at last birthday: _____

City and State or County

(Continued)

10-10-68

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 08-11-2010 BY 60322 UCBAW

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

11-11-1964

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of PAYETTE
City of PAYETTE
No. 1536-1rst.Ave.8p.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

188302

Registration District No. 4 State File No. 1008.

Prim. Registration District No. 1008. Local Registrar's No. 73

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	{ and } Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>Dec. 29, 1930</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None.

Number of child of this mother, including present birth. 1 (a) Born alive and now living 0
Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>Theodore Edward Newton</u> Residence (Usual place of abode) <u>Payette, Idaho</u> If non-resident, give place and State <u> </u> Color or race <u>White</u> Age at last Birthday <u>25</u> Birthplace <u>Oregon</u> (City and State or County) Occupation <u>Lumberman</u>	MOTHER FULL MAIDEN NAME <u>Eunice Adele Stringer.</u> Residence (Usual place of abode) <u>Payette, Idaho</u> If non-resident, give place and State <u> </u> Color or race <u>White</u> Age at last Birthday <u>23.</u> Birthplace <u>Washington</u> (City and State or County) Occupation <u>Wife</u>
--	---

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 8.00am. M.
on the date above stated. (Signature) J. C. Woodward, M.D.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Physician
(Physician or midwife)

Address Payette, Idaho.

Filed Dec 31 1931 J. C. Woodward
Registrar.

2

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County of PAYETTE.
City of PAYETTE.

Registration District No. 4.Primary Registration District No. 1008.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME STILLBORN INFANT OF THEODORE EDWARD NEWTON(a) Residence. No. DONA DORENE NEWTON. St.

(Usual place of abode.)

(If nonresident give city or town and State.)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word.) Stillborn

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 29, 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work -----

(b) General nature of industry, business, or establishment in which employed (or employer) -----

(c) Name of employer -----

9. BIRTHPLACE (city or town) Payette, Idaho.
(State or country)10. NAME OF FATHER Theodore Edward Newton.11. BIRTHPLACE OF FATHER (city or town) Oregon.
(State or Country)12. MAIDEN NAME OF MOTHER Eunice Adele Stringer13. BIRTHPLACE OF MOTHER (city or town) Wash.
(State or Country)14. Informant Theodore Edward Newton
(Address) Payette, Idaho15. Filed Dec 29, 1930 J. C. Woodward
Registrar

DO NOT WRITE IN THIS SPACE

State File No. 73874Local Registrar's No. 45

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 29, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 29, 1930, to Dec. 29, 1930that I last saw him alive on 8.00 am

and that death occurred, on the date stated above, at

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Stillborn-Dystocia.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) 12/29/30, 19 M. D. Payette, Idaho.
(Address)

19. Place of Burial, Cremation, or Removal

New Plymouth, Id.

Date of Burial

12/29/30

20. Undertaker

Theodore Ed. Newton

Address

Payette, Id

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Saleman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile Factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home**, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At Home**, and children not gainfully employed, as **At school or At Home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia**; **Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.**, **Carcinoma, Sarcoma, etc.**, of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping Cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably such**, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of PAYETTE
City of _____
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

188303

Registration District No. 4 State File No. _____

(If born in hospital or institution
give name.)

Prim. Registration District No. 1008 Local Registrar's No. 2

FULL NAME OF CHILD

Stillbirth.

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	{ and } Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>Dec. 24, 1930</u> (Month) (Day) (Year)
--------------------------	---	--	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? None.

Number of child of this mother, including present birth. 1 (a) Born alive and now living 0

Born alive but now dead. 0 Stillborn 1

FATHER FULL NAME <u>David Sesena.</u>	MOTHER FULL MAIDEN NAME <u>Welsie Creech.</u>
--	--

Residence (Usual place of abode) Payette, Idaho

If non-resident, give place and State. _____

Color or race White Age at last Birthday 21
(Years)

Birthplace Oregon
(City and State or County)

Occupation Farmer.

If non-resident, give place and State. _____

Color or race White Age at last Birthday 18
(Years)

Birthplace Montana.
(City and State or County)

Occupation Wife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 3.00am. M.
on the date above stated.

(Signature) J. C. Woodward
Physician.
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Payette, Idaho.

Filed Dec 31 1931 J. C. Woodward
Registrar.

RECEIVED
JAN 10 1930
U.S. DEPARTMENT OF JUSTICE
DIVISION OF INVESTIGATION
WASHINGTON, D.C.

It was found that the father of the child was a white male, born in Oregon, and that the mother was a white female, born in Oregon. The child was born on January 10, 1930, at the home of the mother.

I hereby certify that I attended the birth of this child, who was born on January 10, 1930, at the home of the mother.

Witness my hand and the seal of the Division of Investigation, at Washington, D.C., this 10th day of January, 1930.

Special Agent in Charge
Division of Investigation
U.S. Department of Justice

Psychic, Isaac.

FATHER
David Segena.

MOTHER
Mabel Segena.

None.

FILE NAME OF CHILD

THE NAME OF THE CHILD AS APPEARING ON

OFFICIAL RECORD

1000 Local Hospital

Birth Date

188303

DEPARTMENT OF JUSTICE
DIVISION OF INVESTIGATION

2

188503

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Oregon State Board of Health

RECEIVED
Certificate of Death

74198

1. PLACE OF DEATH *Payette* State Registered No. *48*
 County *Madison* State *Ore* Local Registered No. *48*
 Township _____ or Village _____
 City *Payette* No. _____ St. _____ Ward _____
 (If death occurred in a hospital or institution, give its name instead of street number)
 Length of residence in city or town where death occurred _____ yrs. mos. da. How long in U. S., if of foreign birth? _____ yrs. mos. da.
 2. FULL NAME *Baby of D. R. Leserna*
 (a) Residence: No. *Payette* St. _____
 (Usual place of abode) (If nonresident, give city or town and state)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX *m* 4. COLOR OR RACE *White* 5. Single, Married, Widowed or divorced (write the word) *m*
 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____
 6. DATE OF BIRTH (month, day, and year) *Dec 24, 1930*
 7. AGE Years _____ Months _____ Days _____ If less than 1 day, _____ hrs. or _____ min.
Street my (no age)
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as silk mill, sawmill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (city or town) (State or country) *Payette Idh*
 13. NAME *D. R. Leserna*
 14. BIRTHPLACE (city or town) (State or country) *Oregon*
 15. MAIDEN NAME *Creech*
 16. BIRTHPLACE (city or town) (State or country) *mont*
 17. INFORMANT *D. R. Leserna*
 (Address) *Payette, Ida*
 18. BURIAL, CREMATION OR REMOVAL Place *Payette, Ida* Date *Jan 24, 1931*
 19. UNDERTAKER *D. R. Leserna*
 (Address) *Payette, Ore*
 20. Filed *Dec 31, 1930* *J. C. Woodward* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) *Dec 24, 1930*
 22. I HEREBY CERTIFY, That I attended deceased from *12/24/30* to *12/24/30*, 19____, that I last saw him alive on *12/24/30*; death is said to have occurred on the date stated above, at _____ m. The principal cause of death and related causes of importance in order of onset were as follows:
Angioma
Enlarged Prostate
 Contributory causes of importance not related to principal cause:
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____
 23. If death was due to external causes (violence) fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and state)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? _____ If so, specify _____
 (Signed) *J. C. Woodward* M. D.
 (Address) *Payette, Ida*

UNITED STATES STANDARD CERTIFICATE OF DEATH

OCT 14 1975

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed on account of the disease causing death, report the occupation prior to illness. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as *at school* or *at home*. For a woman whose only occupation was that of home housework, write *housework* in answer to Question 8 and *own home* in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as *housekeeper—private family*, *cook—hotel*, etc. For a person who had no occupation whatever write *none*.

To be complete, an occupation return must state:

8. The trade, profession, or particular kind of work done.
9. The industry or business in which the work was done.
10. The month and year the deceased last worked at the occupation.
11. The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as *spinner*, *weaver*, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as *grocery store*, *soap factory*, *cotton mill*, etc.

Distinguish carefully the different kind of engineers by stating the full descriptive titles, as *civil engineer*, *mechanical engineer*, *mining engineer*, *stationary engineer*, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as *carpenter*, *painter*, *machinist*, etc. Distinguish carefully between *retail merchants* and *wholesale merchants*. A person who sells goods should be called a *salesman* and not a *clerk*.

Statement of cause of death—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthma, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under contributory causes of importance not related to principal cause, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance in order of onset were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Contributory causes of importance not related to principal cause:

<i>Fracture of arm</i>	
<i>Automobile accident</i>	<i>May 3, 1927</i>

Example II

The principal cause of death and related causes of importance in order of onset were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Contributory causes of importance not related to principal cause:

<i>Influenza</i>	<i>6 weeks ago</i>
------------------	--------------------

In a group of causes containing the principal cause and related causes, the causes should be given in the order of onset, so that in a group of three causes the principal cause may appear in either first, second, or third position. The principal cause in each of the above examples happens to be the second cause given.

Additional Space for Further Statements by Physician

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

793-238-038-693

PLACE OF BIRTH

County of Payette
City of Payette
No. St.

(If born in hospital or institution give name.)

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and <u> </u>	Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>Dec</u> <u>30</u> <u>1930</u>
			(To be answered only in event of plural births)		(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 7 (a) Born alive and now living 2

Born alive but now dead Stillborn 5

FATHER	MOTHER
FULL NAME <u>Guy L. Lutzman</u>	FULL MAIDEN NAME <u>Mabel Orcutt</u>
Residence (Usual place of abode) <u>Payette, Idaho</u>	Residence (Usual place of abode) <u>Payette, Idaho</u>
If non-resident, give place and State <u> </u>	If non-resident, give place and State <u> </u>
Color or race <u>White</u> Age at last Birthday <u>37</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>38</u> (Years)
Birthplace <u>Payette, Idaho</u> (City and State or County)	Birthplace <u>Minnesota</u> (City and State or County)
Occupation <u>Labourer</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 5 P M. on the date above stated.

(Signature) F. A. Benjamin M.D.

(Physician or midwife)

Address Payette, Idaho

Filed Dec 31 1930 J. C. Woodward Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

512-115 040-792

PLACE OF BIRTH

County of Shoshone

City of Kellogg

No. _____ St. _____

Kellogg Maternity Home
(If born in hospital or institution
give name.)

Registration District No. _____ State File No. _____

Prim. Registration District No. _____ Local Registrar's No. 8

FULL NAME OF CHILD Stillborn — Vasiloff

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Boy</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Sept. 15</u> 19 <u>39</u> (Month) (Day) (Year)
-------------------------	---	-----	--------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? argyrol 1090

Number of child of this mother, including present birth. 2 (a) Born alive and now living 1

Born alive but now dead. 0 Stillborn 1

FULL NAME FATHER Peter Vasiloff

Residence (Usual place of abode) 77 arden

If non-resident, give place and State _____

Color or race Irish Age at last Birthday 31 (Years)

Birthplace Irish
(City and State or County)

Occupation Laborer

FULL MAIDEN NAME MOTHER Mary Gibson

Residence (Usual place of abode) 77 arden

If non-resident, give place and State _____

Color or race White Age at last Birthday 34 (Years)

Birthplace ? Don't know
(City and State or County)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn ^{born alive} at 4:30 P. M.
on the date above stated.

(Signature) W. C. Lindsay

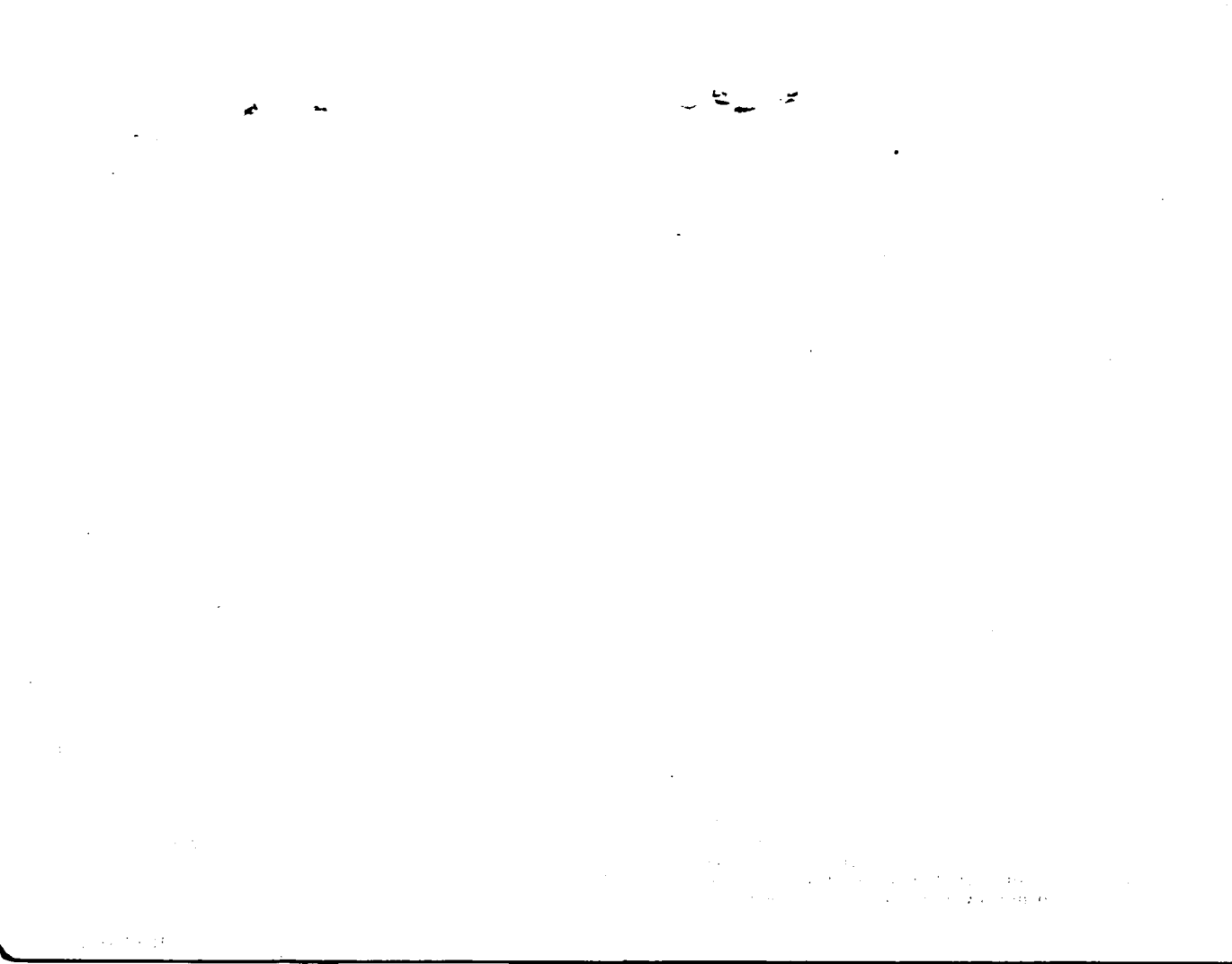
Physician
(Physician or midwife)

Address Kellogg Idaho

Filed Feb. 27 1939 Mrs. Helen M. Bailey

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72169

PLACE OF DEATH

County of ShoshoneCity of KelloggRegistration District No. 123Primary Registration District No. 2201Local Registrar's No. 45

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Vasiloff(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word)5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Sept. 15, 19307. AGE Years Months Days If LESS than 1 day,
Still hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Kellogg Idaho
(State or country)10. NAME OF FATHER Peter Vasiloff11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Constantinople12. MAIDEN NAME OF MOTHER Mary Gibson13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Wood River Oregon14. Informant Peter Vasiloff
(Address) Kellogg Idaho15. Filed Sept. 28, 1930 Mrs. Helen M. McBride
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 15 19 30
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Sept 15, 1930, to Sept, 1930that I last saw him alive on , 1930and that death occurred, on the date stated above, at m.The CAUSE OF DEATH* was as follows:
Break Delivery

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death? Kellogg IdahoDid an operation precede death? No Date of Was there an autopsy? NoWhat test confirmed diagnosis? (Signed) W. L. Linsley, M. D.1116, 1930 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Kellogg Idaho Sept 16 1930

20. Undertaker Address

P. L. Stout Kellogg Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

204

188966 +

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH 813211

County of Bennock 003-557
City of Pocatello
No. St Anth cny St.

Hosp

(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 28 State File No. 189124

Prim. Registration District No. 261 Local Registrar's No. 10155

FULL NAME OF CHILD Stillborn Hatch

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u> { and } Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>12/11/30/</u> 19 <u>31</u>
	(To be answered only in event of plural births)		(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Neo-Silvol

Number of child of this mother, including present birth 6 (a) Born alive and now living 4

Born alive but now dead 2 Stillborn 1

FATHER
FULL NAME Simmons F Hatch

Residence (Usual place of abode) Robin Idaho

If non-resident, give place and State

Color or race W Age at last Birthday 40
(Years)

Birthplace Franklin Utah
(City and State or County)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Tressa England

Residence (Usual place of abode) Robin Idaho

If non-resident, give place and State

Color or race W Age at last Birthday 40
(Years)

Birthplace Plain City Utah
(City and State or County)

Occupation H. W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive }
on the date above stated. Stillborn No I. 45 A. M.

(Signature) H. C. Cail

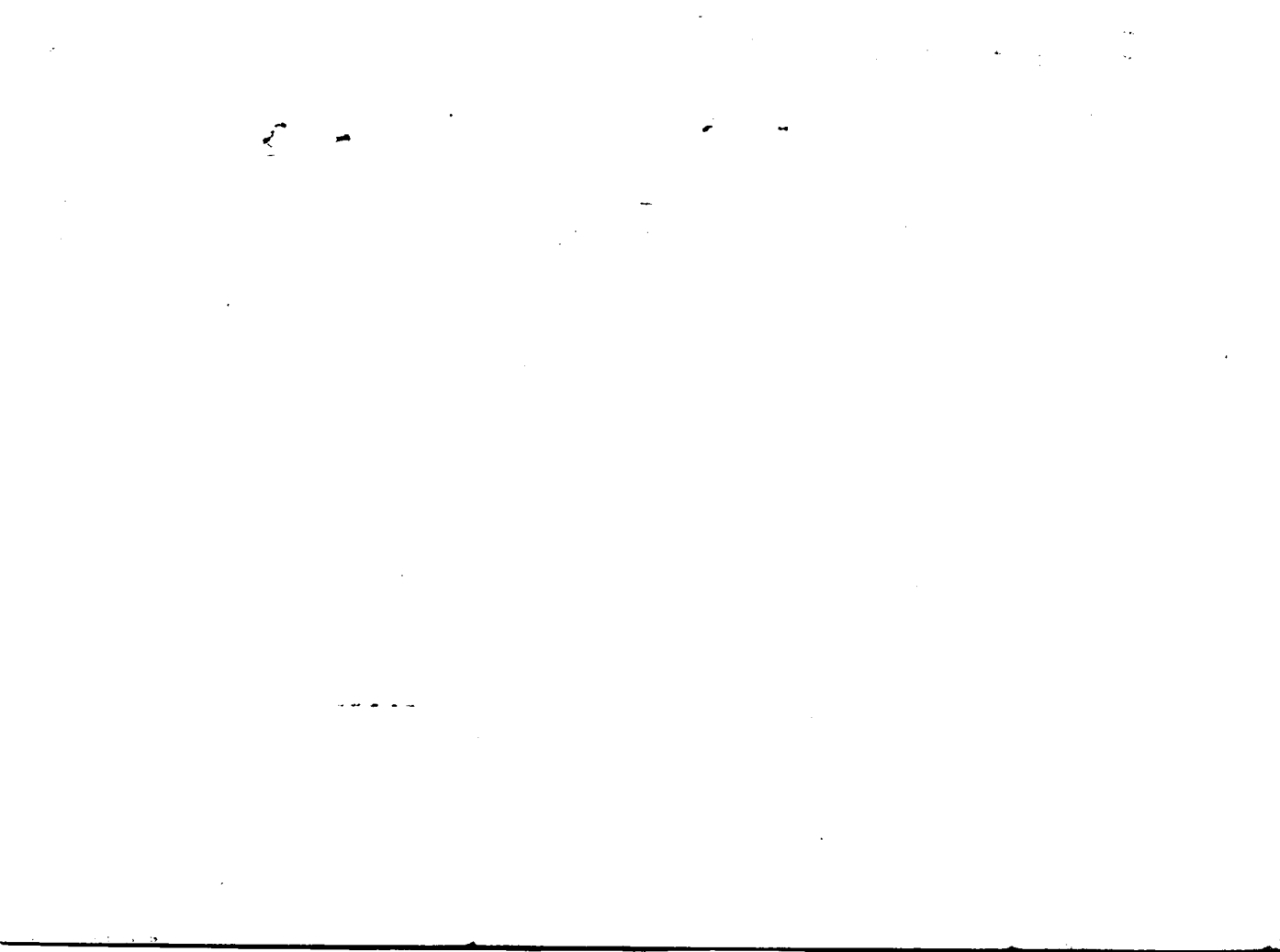
(Physician or midwife)

Address Pocatello, Ida

Filed 3-1 1931 D. C. Ray

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.

Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 72988

PLACE OF DEATH

County of Bannock
City of Pocatello

CERTIFICATE OF DEATH

Registration District No. 28
Primary Registration District No. 2161
(No. St. Anthony Hospital)

Local Registrar's No. 5957

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Hatch

(a) Residence. No. Moreland Idaho St.

(Usual place of abode.)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) December 11, 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello Idaho
(State or country)

10. NAME OF FATHER S.F. Hatch

11. BIRTHPLACE OF FATHER (city or town) Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Tressa England

13. BIRTHPLACE OF MOTHER (city or town) Utah
(State or Country)

14. Informant S.F. Hatch
(Address)

15. Filed 12/12/30 19
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
December 11, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19
that I last saw him alive on 19
and that death occurred, on the date stated above, at 19.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

The mother was sick
by a surgery for
about 10 days, her delivery
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.
12/12, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal Moreland Idaho Date of Burial 12/12/30 19

20. Undertaker Arthur W. Hall Address Poca. Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer Farm laborer. Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid House-keepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of** (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

STATE OF ILLINOIS
 COUNTY OF Greene
 City of Princeton
 No. 723 So 3rd
444-113 003 951
 RECEIVED JUN 20 1956
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS
 CHICAGO, ILL.
 Registered District No. 28
 Prim. Registration District No. 261 Local Registrar's No. 793
201956

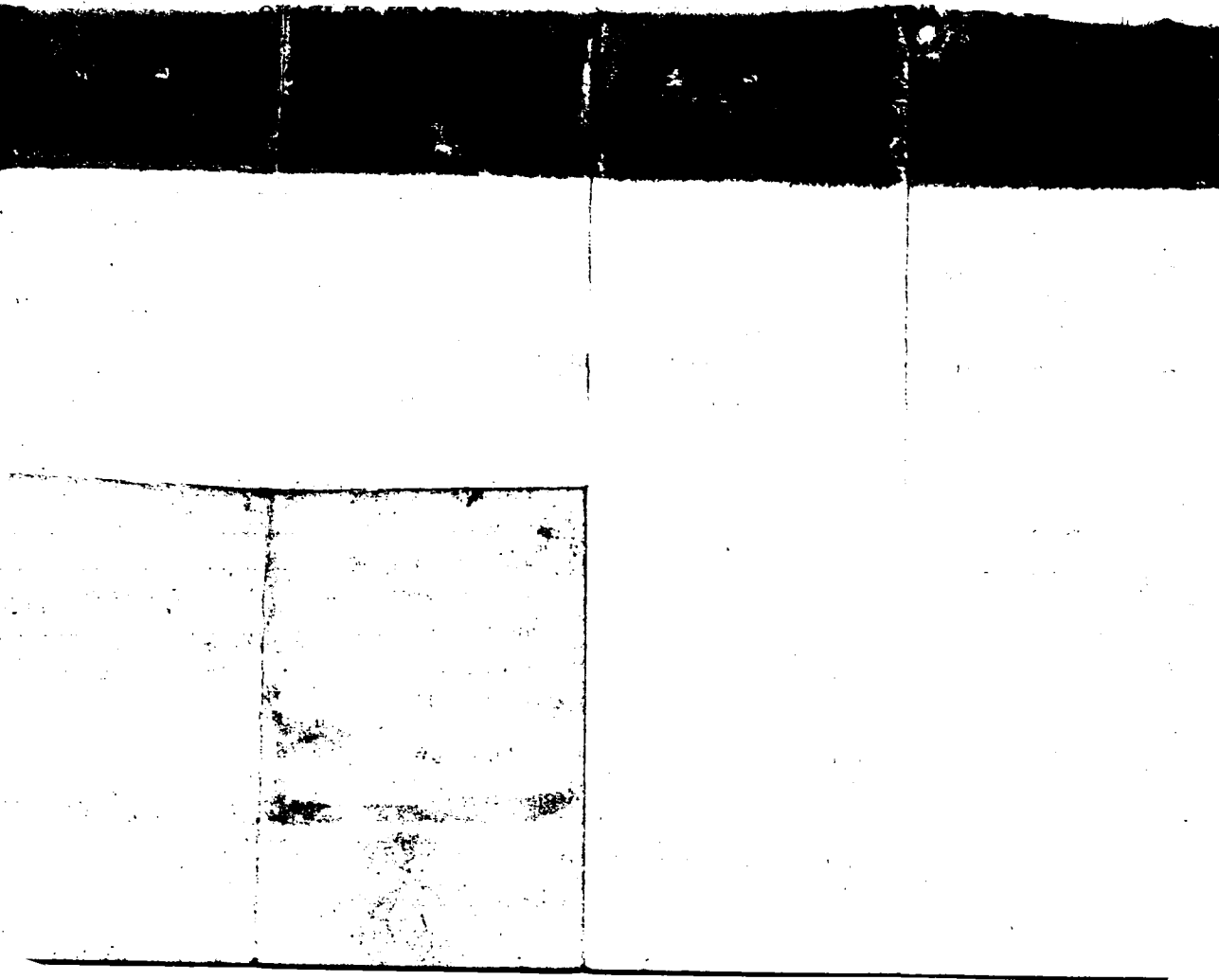
(If born in hospital or institution give name.)
 FULL NAME OF CHILD Stillbirth Mauve
 (If stillborn, substitute the word "Stillbirth" for name of child)
 Sex of Child boy Twin Triplet or other? - and - Number in order of birth - Legitimate? No Date of birth Dec. 13 1956
 (Month) (Day) (Year)
 What prophylactic was used to prevent Ophthalmia Neonatorum? 174 gm
 Number of child of this mother, including present birth 1 (a) Born alive and now living 1
 Born alive but now dead None Stillborn 1
 FATHER FULL MAIDEN NAME
 FULL NAME Mauve Helen Mayors Heaps
 Residence (Usual place of abode) Princeton, Idaho Princeton, Idaho
 If non-resident, give place and State
 Color or race white Age at last Birthday 25 (Years) Color or race white Age at last Birthday 2 (Years)
 Birthplace Oklahoma (City and State or County) Birthplace Salt Lake City, Utah (City and State or County)
 Occupation laborer Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at Princeton, Idaho on the date above stated.
 (Signature) W. W. Brothers

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
 Address Princeton, Idaho
 Filed 5-31 1956 D C Ray
 Registrar



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
Physician should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

PHYSICIAN

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72987

PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. _____

Primary Registration District No. 2161

(No. Pocatello General Hospital)

Local Registrar's No. 5958

2. FULL NAME

Infant Maury

(a) Residence No. 723-3rd

St. _____

Length of residence in city or town where death occurred. yrs. mos. ds.

How long in U. S. if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word.) none

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6. DATE OF BIRTH (month, day and year) Dec. 13-1930

7. AGE Years _____ Months _____ Days _____ LESS than 1 day, hrs. or min. 13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Pocatello
(State or country) Idaho

10. NAME OF FATHER O. L. Maury

11. BIRTHPLACE OF FATHER (city or town) Okla.
(State or Country)

12. MAIDEN NAME OF MOTHER Helen Heaps

13. BIRTHPLACE OF MOTHER (city or town) Utah
(State or County)

14. Informant (Address) Mr. O. L. Maury

15. Filed 12/15-30 Registrar J. H. Young

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 13-1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13, 1930, to Dec 13, 1930
that I last saw him alive on Dec 13, 1930

and that death occurred, on the date stated above, at 2:30 p. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Stelectasis

(duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ da.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) W. B. Brotherton, M. D.
12-14-30 (Address) Pocatello, Idaho

19. Place of Burial, Cremation, or Removal Mt. View Cemetery Date of Burial 12-14-1930

20. Undertaker H. L. McBar Address Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of** (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL Septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.